

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

104575

CERTIFICATE OF DEATH

04573

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE	
Allegany MARYLAND		Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Water Station Run		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		First	Middle
Jane		Graham	Andrews
4. DATE OF DEATH		Month	Day Year
April 6 19 66			
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Female		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
House Wife		11. BIRTHPLACE (County & State, or foreign country)	
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY?	
William Waddell		U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
		17. INFORMANT	
		Mrs. Delma Cook, Daughter	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		7 days	
DUE TO (b)		Myocardial Ischemia	
DUE TO (c)		Arterosclerotic CV Disease	
7 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Advanced coronary artery disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 5, 1966, to April 6, 1966, that (I) (we) last saw the deceased alive on May 30, 1966, and that death occurred at A M, from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE		4.7.66	
22c. PHYSICIAN'S NAME (Type)		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
L.R. MILES JR MD		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
Burial		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS	
4/9/66		Oak Hill Cemetery	
24. FUNERAL DIRECTOR		23d. LOCATION (City, town or county) (State)	
George Eichhorn		Lonaconing, Md.	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
APR 12 1966		Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

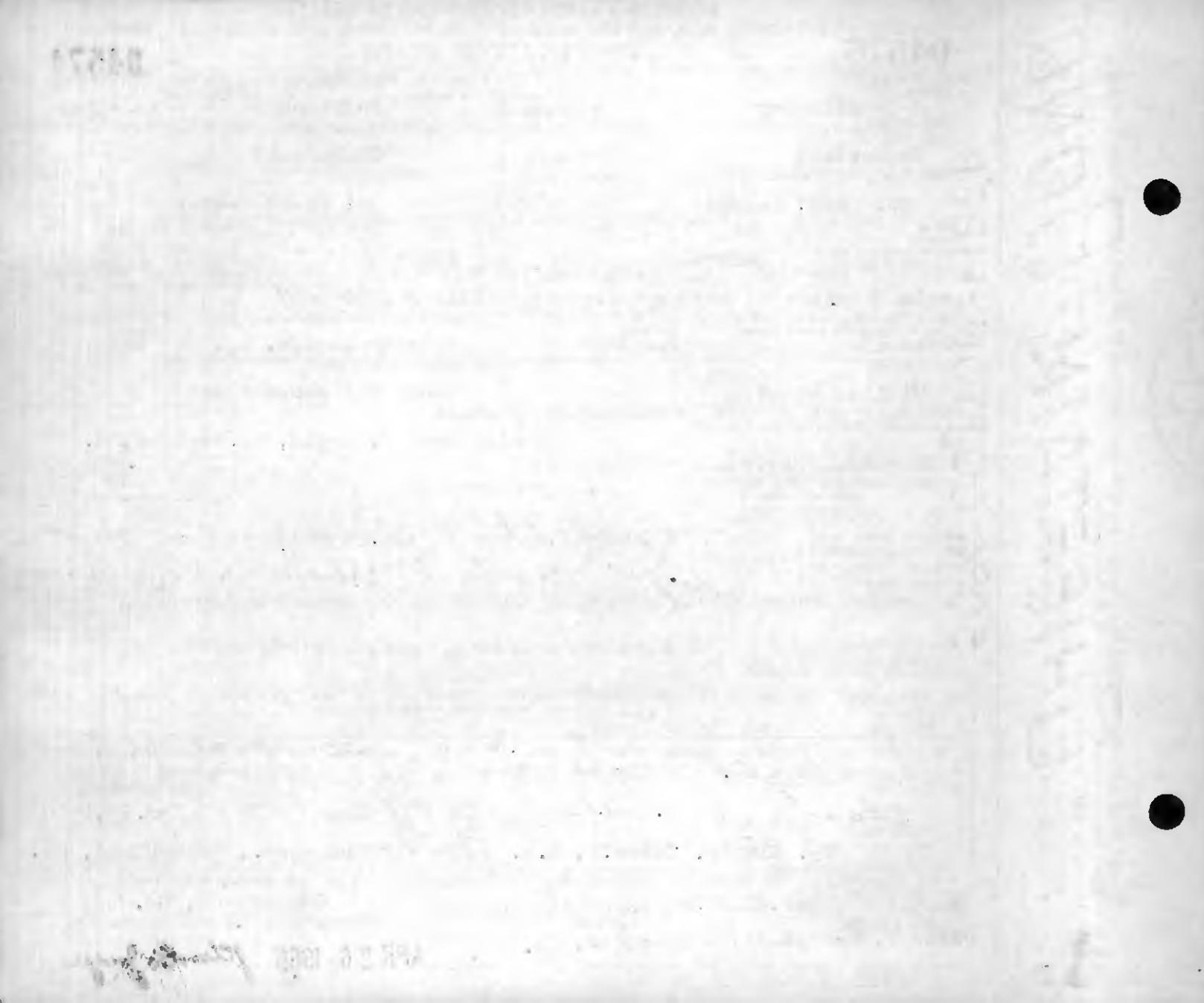
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1 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04576

CERTIFICATE OF DEATH

04574

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 65 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 301 Grand Avenue		e. STREET ADDRESS 301 Grand Avenue	
3. NAME OF DECEASED (Type or print) Agnes Rose Apple		4. DATE OF DEATH April 21 19 66	Month Day Year
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH July 18, 1878 87	
9. ACE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Orleans Road, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Light		14. MOTHER'S MAIDEN NAME Rose Ann Householder	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 17. INFORMANT Miss Mary R. Apple, Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4222 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. myocarditis & Decompensation 6 mon DUE TO (b) Left Cerebral Haemorrhage 10 mon DUE TO (c) Haemorrhage 7 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 20 to Apr 21 , 1966, that (I) (we) last saw the deceased alive on Apr 21 1966 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE Clay E. Durrett		22b. DATE SIGNED Apr. 22, 1966	
22c. PHYSICIAN'S NAME (Type) Dr. Clay E. Durrett, M.D.		22d. ADDRESS 236 Virginia Ave., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 23, 1966	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Rose Hill Cemetery
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR APR 26 1966	
		25b. REGISTRAR'S SIGNATURE James F. Scarpelli, Cumberland, Md.	



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04577

CERTIFICATE OF DEATH

04575

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND-Allegany MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 25 MIN.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. STREET ADDRESS 100 East Main St.	
3. NAME OF DECEASED (Type or print) BABY		First GIRL	Middle BAKER
4. DATE OF DEATH APRIL 7, 1966	Month APRIL	Day 7	Year 1966
5. SEX WHITE	6. COLOR OR RACE FEMALE	7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH APRIL 7, 1966
9. AGE (In years last birthday) 0 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
13. IF UNDER 24 HRS. Min 25	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME MOWRY BAKER		
14. MOTHER'S MAIDEN NAME THELMA HUTZEL	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	16. SOCIAL SECURITY NO. none	17. INFORMANT Address MEMORIAL HOSPITAL
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7615 <i>Obxoxa</i> INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Prolapge cord</i> (c) <i>Breech presentation - prematurity</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? NO			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 19 , and that death occurred at 19 , at 2:20 P.M. , on 19 , that (I) (we) last M, from causes and on the date stated above.	22b. DATE SIGNED		
22a. SIGNATURE <i>Américo T. Valdes MD</i>	M.D. ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) DR. AMERICO T. VALDES	22d. ADDRESS ALGONQUIN HOTEL, CUMB. MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Apr. 8, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Frostburg Memorial Park	23d. LOCATION (City or Town) (County) (State) Frostburg, Md.
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.	ADDRESS	25a. RECEIVED BY REGISTRAR APR 14 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
VR A15 (4) 20 M 1/66			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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04578

CERTIFICATE OF DEATH

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 18 DAYS						
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 103 DECATUR ST.						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) BREXX PAULINE		First MARY	Middle BECK					
4. DATE OF DEATH APRIL 5 1966		Month Day Year	Day Year					
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED WIDOWED	8. NEVER MARRIED DIVORCED	9. DATE OF BIRTH NOV. 5, 1904	10. AGE (In years last birthday) 61 yrs.	11. IF UNDER 1 YEAR Months Days Hours Min.	12. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME JOHN DEAN		14. MOTHER'S MAIDEN NAME ROSE BARTALON						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-05-5930		17. INFORMANT DAWRT		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) Genuinely advanced cerebral arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH years				
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>March 30, 1966</u> , to <u>April 8, 1966</u> , that (I) (we) last saw the deceased alive on <u>April 5, 1966</u> , and that death occurred at <u>M</u> , from causes and on the date stated above.								
22a. SIGNATURE <u>B. M. Schindler</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/6/66				
22c. PHYSICIAN'S NAME (Type) B. M. SCHINDLER, M.D.		22d. ADDRESS 43 GREENE ST. CUMBERLAND, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF APRIL 11, 1966		23c. NAME OF CEMETERY OR CREMATORIUM ST. MARYS CEMETERY		23d. LOCATION (City or Town) CUMBERLAND, MD. (County) (State)		
24. FUNERAL DIRECTOR BYRON KIGHT		ADDRESS CUMBERLAND, MD.		25a. RECD BY REGISTRAR APR 11 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

MARYLAND STATE DEPARTMENT OF HEALTH

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04579

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1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b 1 WEEK	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MINERS HOSPITAL		d. STREET ADDRESS 76 BOWERY STREET	
3. NAME OF DECEASED (Type or print) LOTTIE	First SARAH	Middle BEVAN	4. DATE OF DEATH APRIL 22, 1966
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> JANUARY 21, 1903 63 yrs.	9. AGE (In years last birthday) IF UNDER 1 YEAR Months Deys Hours Min. 63 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMSTRESS		10b. KIND OF BUSINESS OR INDUSTRY SHIRT FACTORY	11. BIRTHPLACE (County & State, or foreign country) U.S.A.
13. FATHER'S NAME VINCENT S. RECKLEY		14. MOTHER'S MAIDEN NAME MARGARET DAILEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service) NO		16. SOCIAL SECURITY NO. MR. EDWARD V. BEVAN, 76 BOWERY STREET	17. INFORMANT Address FROSTBURG, MD.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 4301 <i>Coronary Artery Heart Disease</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cancer of the Intestinal Tract</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, Farm, factory, street, office-bldg., etc.)
20f. (City or town) 4115		(County) 1966	
(State) MD.			
21. I certify that (I) (this hospital) attended the deceased from 4/15/66 to 4/22/66 , that (I) (we) last saw the deceased alive on 4/22/66 , and that death occurred at 4/22/66 from the causes and on the date stated above.			
22a. SIGNATURE <i>Martin M. Rothstein, M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 4/24/66
22c. PHYSICIAN'S NAME (Type) MARTIN M. ROTHSTEIN, M.D.		22d. ADDRESS 48 BOWERY STREET, FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF APRIL 25, 1966	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS FROSTBURG MEM. PARK
24. FUNERAL DIRECTOR'S SIGNATURE <i>Maria J. Seaw</i>		23d. LOCATION (City, town or county) FROSTBURG	(State) MD.
ADDRESS HAFER FUNERAL HOME, 60 W. MAIN ST.		25a. REC'D BY REGISTRAR APR 26 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

MARYLAND STATE DEPARTMENT OF HEALTH
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b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,		c. LENGTH OF STAY IN 1b 7 HRS.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WELLERSBURG		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROSETTA		First MAY	Middle BRANT
4. DATE OF DEATH 4-23-66		Month Month	Day Day
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH APRIL 13, 1917		9. AGE (in years (last birthday) yrs. 50	10. IF UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (County & State or foreign country) Wellersburg, Pa.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Lillian Sturtz	
14. MOTHER'S MAIDEN NAME Goldie Sturtz		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO 123-45-6789		17. INFORMANT John St. Amans, Wellersburg, Pa.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE, MASSIVE		INTERVAL BETWEEN ONSET AND DEATH 2 DAYS	
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause Malignant Hypertension		DUE TO (b) MALIGNANT HYPERTENSION DUE TO (c) HYPERTENSIVE HEART DISEASE	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) LEFT HEMIPLEGIA	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE	
20c. TIME OF INJURY Month, Day, Year Hour a.m. None 19 p.m. None		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None
20f. (City or town) None		(County) None	
		(State) None	
21. I certify that (I) (this hospital) attended the deceased from APRIL 22, 1966 , to APRIL 23, 1966 , that (I) (we) last saw the deceased alive on APRIL 23, 1966 , and that death occurred at 1:20AM , from causes and on the date stated above.		22d. DATE SIGNED 4-23-66	
22e. SIGNATURE James P. Hallinan M.D.		22d. ADDRESS 140 Bedford St. CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 23, 1966	23c. NAME OF CEMETERY OR CREMATORIAL 3rd & 4th Street Methodist Cemetery, Cumberland, Maryland
23d. LOCATION (City or Town) Cumberland, Maryland		(County) None	
		(State) None	
24. FUNERAL DIRECTOR Howard H. Zeigler		25. ADDRESS None	25a. RECEIVED BY REGISTRAR DATE APR 29 1966
		25b. REGISTRAR'S SIGNATURE Charles Judge	

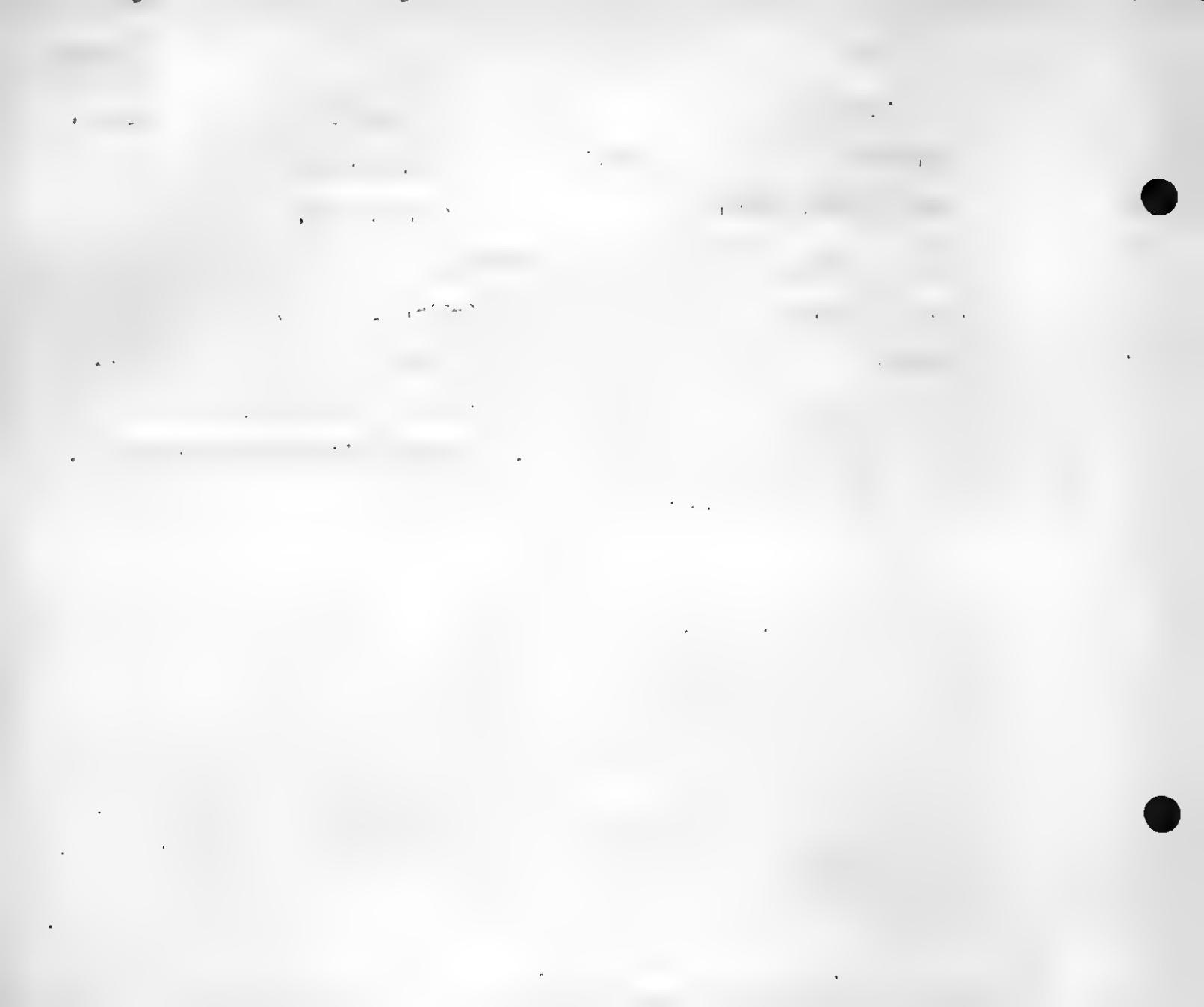


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial transit permit. Then, please remove carbon papers. Pages 1 and 2, director, page 3 should be detached for use as the burial, cremation, or removal, and in any event, within 72 hours after death should be filed with the State Dept. of Health prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												04579			
CERTIFICATE OF DEATH															
1. PLACE OF DEATH a. COUNTY ALLEGANY						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND						b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND						c. LENGTH OF STAY IN 1b 7 DAYS						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL						d. STREET ADDRESS 520 FECTIG ST.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First ANNA		Middle L		Last BROOKS		4. DATE OF DEATH 4 29 1966		Month	Day	Year			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 2-21-1893		9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY Own Home			11. BIRTHPLACE (County & State, or foreign country) MD			12. CITIZEN OF WHAT COUNTRY? U.S.						
13. FATHER'S NAME Walter Hensel		14. MOTHER'S MAIDEN NAME Sarah E. (Shaw) Hensel													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. None		17. INFORMANT SON FRANKLIN SCHILLING		18. CAUSE OF DEATH (Enter only one cause, per line for (a), (b), and (c).-1) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Myocardial Infarction 4201 Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH							
DUE TO (b) DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus													
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 4/22, 1966		(County) 1966		(State) 4/29, 1966					
21. I certify that (I) (this hospital) attended the deceased from 4/28, 1966 to 4/29, 1966 , that (I) (we) last saw the deceased alive on 4/28, 1966 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.															
22a. SIGNATURE Leo H. Ley Jr.															
22c. PHYSICIAN'S NAME (Type) Leo H. Ley Jr.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/29/66							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 2, 1966		23c. NAME OF CEMETERY OR CREMATORIUM ADDRESS Zion Memorial Park		23d. LOCATION (City, town or county) Cumberland		(State) Md.							
24. FUNERAL DIRECTOR Byron Kight		25a. REC'D BY REGISTRAR MAY 3 1966										25b. REGISTRAR'S SIGNATURE Charles Judge			
VR A15 (4 20M 1/65 <i>Byron Kight</i>		DATE										SIGNATURE			



1
M
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04582

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04580

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMG. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 40 YEARS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. STREET ADDRESS 424 N. MECHANIC STREET	
3. NAME OF DECEASED (Type or print) MAUNIE		First E.	Middle BROOME
4. DATE OF DEATH Month APRIL	Day 29	Year 19 66	Month IF UNDER 1 YEAR
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH UNKNOWN
9. AGE (In years last birthday) 70 yrs.	10. IF UNDER 24 HRS. Months 0	11. BIRTHPLACE (State or foreign country) PENNA.	12. IF UNDER 24 HRS. Days 0
13. FATHER'S NAME UNKNOWN	14. MOTHER'S MAIDEN NAME RAY W. BROOME	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT UNKNOWN	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>9/40</i> Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO Fracture of right Hip (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH HOURS 2 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic cardiovascular disease			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Fell at home	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Fell at home	20c. TIME OF INJURY Month, Day, Year Hour 4:00 p.m. April 29 66	
20d. INJURY OCCURRED at work <input type="checkbox"/> Not at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Cumberland, Alleg. Md.	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	22. DATE SIGNED April 30, 1966
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	Address (Street, city, town, or county) Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF MAY 2, 1966	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS OAKLAND CEMETERY	23d. LOCATION (City, town or county) (State) OAKLAND, MD.
24. FUNERAL DIRECTOR BYRON KIGHT	25a. REC'D BY REGISTRAR MAY 3 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04583

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04581

1. PLACE OF DEATH

a. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

EMMEXEMMX Oldtown

c. LENGTH OF STAY IN 1b

1 year

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

none (Oldtown, Md.)

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)

e. STATE

Maryland

b. COUNTY

Allegany

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Oldtown, Md.

✓

d. STREET ADDRESS

none (Oldtown, Md.)

e. IS RESIDENCE
ON A FARM?

YES NO

3. NAME OF

DECEASED
(Type or print)

First

Middle

Last

4.

DATE
OF
DEATH

Month

Day

Year

April 12 1966

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

Nov. 29, 1908

9. AGE (in years
last birthday)

57

10. IF UNDER 1 YEAR

11. IF UNDER 24 HRS.

Yrs.

Months

Days

Hours

MIn.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Pipefitter

10b. KIND OF BUSINESS OR
INDUSTRY

Railroad

11. BIRTHPLACE (State or foreign country)

Cumberland, Md.

12. CITIZEN OF WHAT
COUNTRY?

USA

13. FATHER'S NAME

George M. Buskey

14. MOTHER'S MAIDEN NAME

Catherine Decker

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)

no

16. SOCIAL SECURITY NO.

705-05-4746

17. INFORMANT

Address
Mr. Richard C. Buskey, Cumberland, Md. - Son

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CORONARY OCCLUSION

INTERVAL BETWEEN
ONSET AND DEATH

SUDDEN

4201

Conditions, if any, which
gave rise to Immediate
cause (a), stating the
underlying cause last.

DUE TO

(b)

DUE TO

(c)

CORONARY SCLEROSIS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20e. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion
death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE *Benedict Skitarelic* CHIEF MEDICAL EXAMINER
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D. ASSISTANT MEDICAL EXAMINER

22. DATE SIGNED
DEPUTY MEDICAL EXAMINER April 12, 1966
Address (Street, city, town, or county) Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIUM 23d. LOCATION (City, town or county) (State)
Burial Apr. 15, 1966 SS. Peter & Paul Cemetery Cumberland, Md.

24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md. APR 15 1966 *Charles Judge*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay occurs, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

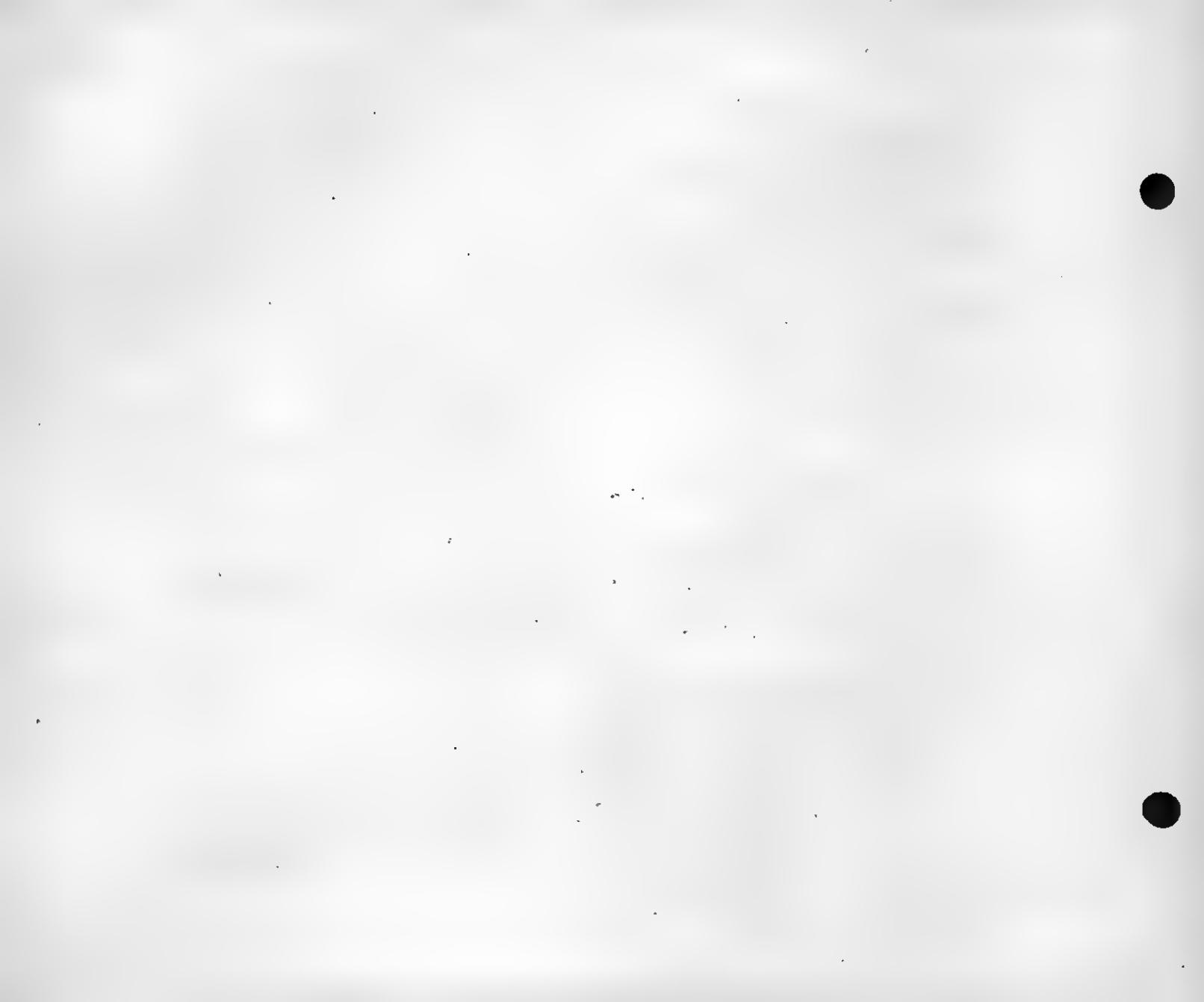
VR A15ME (5)
5M 1/65



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
04584 CERTIFICATE OF DEATH 04582														
1. PLACE OF DEATH a. COUNTY		ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		a. STATE MARYLAND		b. COUNTY ALLEGANY						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		FROSTBURG,		c. LENGTH OF STAY IN 1b		6 WEEKS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		FROSTBURG,				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		MINERS HOSPITAL		d. STREET ADDRESS		37 W. FIRST STREET,		e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year						
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?	13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address 13 N. Lee St., MRS. ANTHONY HOUCK, CUMBERLAND, MD.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]														
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adenocarcinoma</i> DUE TO Conditions, If any, which gave rise to Immediate (b) <i>Primary in Bile ducts.</i> INTERVAL BETWEEN cause (a), stating the (c) <i>Regional & Distant Metastasis</i> ONSET AND DEATH underlying cause last.														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Generalized Atherosclerosis</i>														
20a. MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
		Hour a.m. p.m.		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		19								
21. I certify that (I) (this hospital) attended the deceased from 3-28, 1966, to 4-24, 1966, that (I) (we) last saw the deceased alive on 4-24, 1966, and that death occurred at M, from the causes and on the date stated above.														
22a. SIGNATURE		<i>Alvin J. Walters</i>		M.D.		ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type)		ALVIN J. WALTERS,		11		22d. ADDRESS		48 BROADWAY, FROSTBURG, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town or county)		(State)						
BURIAL		4-27-66		ST. MICHAEL'S CEMETERY		FROSTBURG,		MD.						
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
JOSEPH R. DURST, SR.,		FROSTBURG, MD.		APR 29 1966		jCharles Judge								



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any documents are necessary, please execute in duplicate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04585

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04583

1. PLACE OF DEATH

a. COUNTY

ALLEGANY

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

FROSTBURG

c. LENGTH OF STAY IN 1B

1 DAY

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

MINERS' HOSPITAL

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

APRIL
9,

1966

Month

Day

Year

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. MARRIED NEVER MARRIED

WIDOWED

ALICE

DIVORCED

CLISE

8. DATE OF BIRTH

APRIL 14, 1893

9. AGE (In years
last birthday)

72

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

housewife

10b. KIND OF BUSINESS OR INDUSTRY

OWN HOME

11. BIRTHPLACE (State or foreign country)

LOARTOWN, MARYLAND

13. FATHER'S NAME

JOHN W. BLUBAUGH

14. MOTHER'S MAIDEN NAME

MARY A. LOAR

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)

NO

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

MR. WILLIAM E. CLISE, LOARTOWN, MARYLAND

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

CEREBRAL HEMORRHAGE

INTERVAL BETWEEN
ONSET AND DEATH
HOURS

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause (b).
DUE TO
(b)

DUE TO
(c)

DUE TO
(c)

HYPERTENSIVE CARDIOVASCULAR
DISEASE

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED
While
at work Not While
at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)
(County)

(State)

21 I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DATE SIGNED

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county) April 9, 1966
Cumberland, Md.

EXAMINER'S
NAME (Type)

BENEDICT SKITARELIC, M.D.

22a. BURIAL, CREMATION,
REMOVAL (Specify)

BURIAL

22b. DATE THEREOF
APRIL 12, 1966 VALE SUMMIT CEM.

VALE SUMMIT MARYLAND

23. FUNERAL DIRECTOR

Marley M. Sowers
HAFER FUNERAL HOME, 60 W. MAIN STREET

ADDRESS APR 19 1966

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

VS. ATSM
SM. 9/60

Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

04586

CERTIFICATE OF DEATH

04584

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and detached filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE PENNSYLVANIA						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN b. 7 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYNDMAN					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			d. STREET ADDRESS RT. 1			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ANNIE		First A.	Middle CLITES	Lost	4. DATE OF DEATH APRIL 8 1966	Month APRIL	Day 8	Year 1966	
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 11-3-1905	9. AGE (in years 1st birthday) 80 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of work on life even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA			12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME CHARLES MARTZ				14. MOTHER'S MAIDEN NAME EMMA HOSSELRODE					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO 131-30-7566		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial infarction INTERVAL BETWEEN ONSET AND DEATH 7d DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular disease DUE TO (c)									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Diabetes Mellitus - Hyperglycemic									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1964 to 1966 , that (I) (we) last saw the deceased alive on 4-8-66 , and that death occurred at 6:35 PM , from causes and on the date stated above.									
22a. SIGNATURE William P. James		22b. DATE SIGNED 4/9/66							
22c. PHYSICIAN'S NAME (Type) DR. WILLIAM P. JAMES		22d. ADDRESS 441 N. CENTRE ST.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/11/66		23c. NAME OF CEMETERY OR CREMATORIAL Porter Cemetery		23d. LOCATION (City or Town) (County) (State) Hyndman, Pa. 15711			
24. FUNERAL DIRECTOR Stanley H. Keeley		ADDRESS Hyndman, Pa.		25a. REC'D BY REGISTRAR APR 13 1966			25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

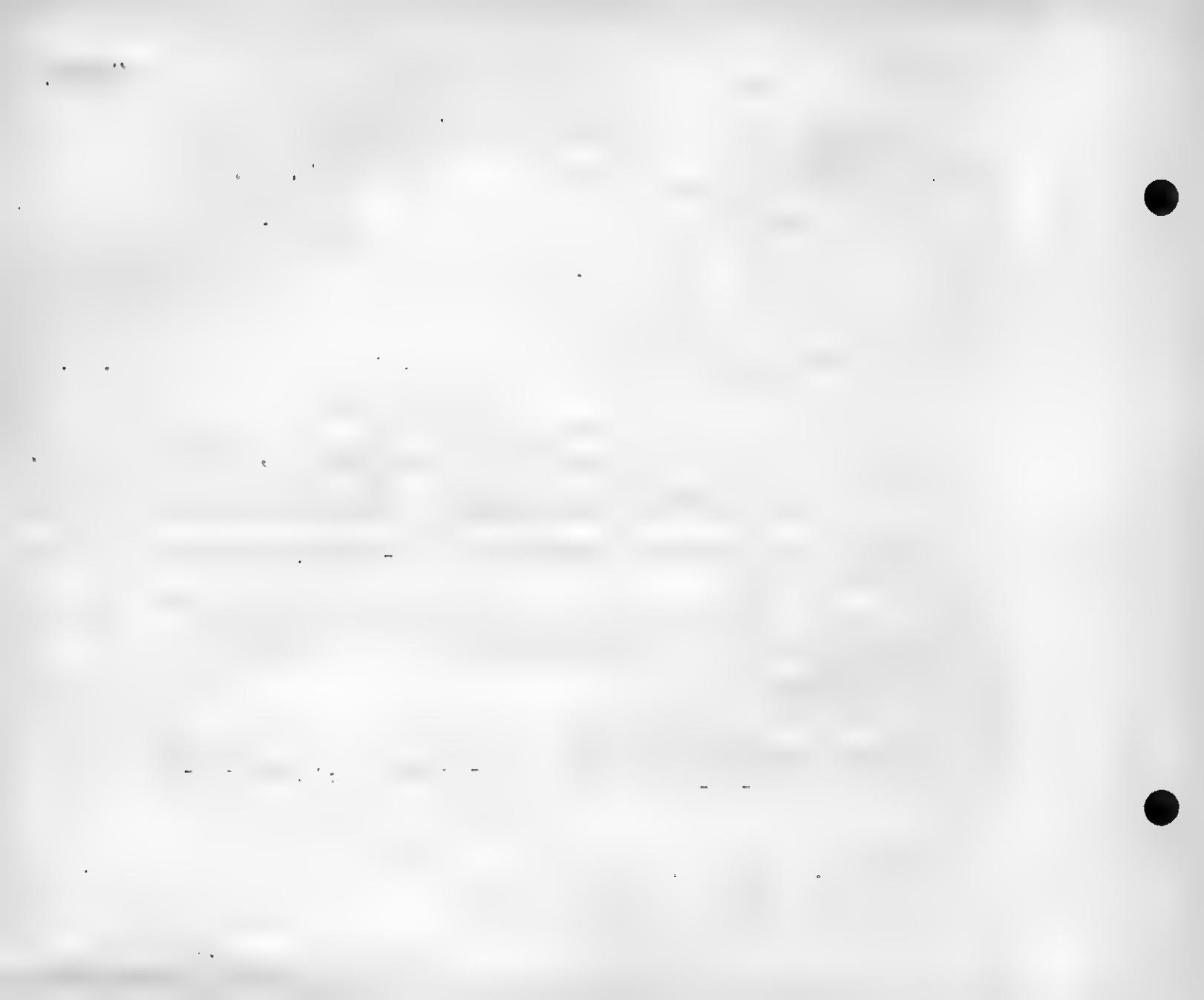
04587

CERTIFICATE OF DEATH

04585

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. STREET ADDRESS 719 ARUNDEL ST.	
3. NAME OF DECEASED (Type or print) ARTHUR		First P.	Middle CONNELL
4. DATE OF DEATH APRIL 11 1966	Month Month	Day Day	Year Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 11-2-1887	9. AGE (In years last birthday) 78 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during mos) of working life, even if retired) Retired Clerk		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas		14. MOTHER'S MAIDEN NAME MARY MURRAY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 705-05-8177	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>id</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DECOMPENSATED HEART DISEASE		INTERVAL BETWEEN ONSET AND DEATH 1 WEEK	
DUE TO (c) ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE		7 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) DIABETES AND PROSTATIC HYPERSTROPHY		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDER, YING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from 11-9-64 to 19 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 4-11-66 19 , and that death occurred at 11:10 PM 4-11-68 , from causes and on the date stated above.		22b. DATE SIGNED 4/12/66	
22c. PHYSICIAN'S NAME (Type) DR. THOMAS F. LUSBY		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS 932 NATIONAL HIGHWAY, La Vale, Md.
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-15-66	23c. NAME OF CEMETERY OR CREMATORIAL St Marys Cemetery
23d. LOCATION (City or Town) Cumberland, Maryland		(County) (State)	
24. FUNERAL DIRECTOR James F. Scarpelli		ADDRESS Cumberland, Md.	25a. REC'D BY REGISTRAR APR 18 1966
			25b. REGISTRAR'S SIGNATURE Charles Judge



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04588

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04588

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
c. LENGTH OF STAY IN 1b 6 years		d. STREET ADDRESS Box 106 Bedford Road, Route 3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 106 Bedford Road, Route 3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ben Middle Casteel Last Covey		4. DATE OF DEATH Month Day Year April 17 1966	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 24, 1888	
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad trainman		11b. KIND OF BUSINESS OR INDUSTRY Railroad C&NW RR	
11. BIRTHPLACE (State or foreign country) Colby, Kansas		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Sam Covey		14. MOTHER'S MAIDEN NAME Janet ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 708 05 7145	
17. INFDRMANT Mrs. Lottie Covey, Box 106, Rt. 3, Cumberland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH Sudden			
4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis (c) ---			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>		20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 17, 1966			
EXAMINER'S NAME (Type) Benedict Skitarelic Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 20, 1966	
23c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Burial Park		23d. LOCATION (City, town or county) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR ADDRESS		25a. REC'D BY REGISTRAR John J. Hafer, 230 Baltimore Ave., Cumberland	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE APR 20 1966	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in pencil in item 18. If any of Pages 1, 2, and 3 are to be forwarded to the Chief Medical Examiner's Office along with Form PM-3, Page 5 may be directed. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE M
HEALTH DEPT.

04589

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04587

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form 5, to be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived) a. STATE		b. INSTITUTION. Residence before admission b. COUNTY			
Allegany Maryland		Maryland		Allegany			
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN b 23 Years		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 225 Carroll Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 225 Carroll Street						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jessie		Middle Deatelhauser		4. DATE OF DEATH Month April		Day 29	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH October 30, 1886	
9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Schilling		14. MOTHER'S MAIDEN NAME Louise Rice		Address 16 Spruce Road Larchmont, N.Y.		15. INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) If yes give war or dates of service No		17. SOCIAL SECURITY NO 213-24-6420		18. INFORMANT Joseph T. Deatelhauser		19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		DUE TO (b) DUE TO (c)		CORONARY OCCLUSION CORONARY SCLEROSIS			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic		MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED April 29, 1966	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/2/66		23c. NAME OF CEMETERY OR CREMATORIAL Rosehill Cemetery		23d. LOCATION (City or Town) (County) (State) Allegany Cumberland Maryland	
24. FUNERAL DIRECTOR Ruth E. Silcox		ADDRESS Cumberland Maryland		25a. REC'D. BY REGISTRAR DATE MAY 2 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

04590

CERTIFICATE OF DEATH

04588

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WIMBERLAD		c. LENGTH OF STAY IN 1b 1 MO. 20 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		e. STREET ADDRESS CORRIGANVILLE	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Bertha		First Bertha	Middle Gehtrude
4. DATE OF DEATH April 13 1966		Lost Delbrook	Month Day Year
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 10-14-88		9. AGE (In years lost birthday) 77 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 15		10b. KIND OF BUSINESS OR INDUSTRY Wellersberg, Pa.	
11. BIRTHPLACE (County & State or foreign country) Wellersberg, Pa.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME George W. Witt		14. MOTHER'S MAIDEN NAME Alice Witt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Patient's Chart		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pulmonary Embolism		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO (b) Respiratory Failure			
DUE TO (c) Severe Second & Third Degree Burns Body			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Feb 20
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Feb 20 , 1966, to April 15 , 1966, that (I) (we) last saw the deceased alive on April 12 , 1966, and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE Richard Schindler		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. R. Schindler		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS 69 Greene St., Cumberland, Md.
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 16, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Wellersburg Cemetery
24. FUNERAL DIRECTOR Harvey H. Feigler		ADDRESS Hyndman, Pa.	25a. REC'D. BY REGISTRAR APR 18 1966
			25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04591

CERTIFICATE OF DEATH

04589

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
 10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please attach to the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN MD 7 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 647 N. MECHANIC ST.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First HALVIN	Middle L.	Last EDWARDS
4. DATE OF DEATH APRIL 13 1966	Month APRIL	Day 13	Year 1966
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 3-18-89	9. AGE (In years 77 last birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME RICHARD EDWARDS		14. MOTHER'S MAIDEN NAME ANNA BUTLER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT PATIENT'S CHART		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Acute Virus Respiratory Disease</i> DUE TO 5272 Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) DUE TO lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Pulmonary Emphysema & Ectasis; Anemia, severe</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>4/15</i> , 1966, to <i>4/13</i> , 1966, that (I) (we) last saw the deceased alive on <i>4/12</i> , 1966, and that death occurred at <i>155</i> M, from causes and on the date stated above.			
22a. SIGNATURE <i>Dr. Leo Ley</i>		22b. DATE SIGNED <i>4/13/66</i>	
22c. PHYSICIAN'S NAME (Type) DR. LEO LEY		22d. ADDRESS 456 N. CENTRE ST., CUMBERLAND, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>April 15, 1966</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Rose Hill Cemetery</i>
24. FUNERAL DIRECTOR <i>Louis Stein, Inc. Cumberland, Md.</i>		23d. LOCATION (City or Town) (County) (State) <i>Cumberland Allegany Md.</i>	
25a. RECD BY REGISTRAR <i>APR 19 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04592

CERTIFICATE OF DEATH

04590

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove from papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY			2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			b. COUNTY ALLEGANY		
c. LENGTH OF STAY IN 1b 28 DAYS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			d. STREET ADDRESS 101 RACE ST.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First AMANDA	Middle MAY	4. DATE OF DEATH EIFERT	Month APRIL	Day Year 5 1966
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-10-1886	9. AGE (in years last birthday) 79 yrs	10. UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State, or foreign country) MARYLAND-CUMBERLAND	
12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME HARTSOCK ENSLEY, HARTSOCK			14. MOTHER'S MAIDEN NAME MARY WILSON		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			16. SOCIAL SECURITY NO 17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD. Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident			INTERVAL BETWEEN ONSET AND DEATH		
DUE TO (b) Pulmonary Infarction					
DUE TO (c) 					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Myocardial Infarction; Thrombosis, left side			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 318	
20f. (City or town) 318		(County) 44		(State) 1966	
21. I certify that (I) (this hospital) attended the deceased from 3/8 , 1966, to 4/4 , 1966, that (I) (we) last saw the deceased alive on 4/4 , 1966, and that death occurred at 3:45 AM from causes and on the date stated above.					
22a. SIGNATURE Leo Ley			22b. DATE SIGNED 4/8/66		
22c. PHYSICIAN'S NAME (Type) DR. LEO LEY			22d. ADDRESS 456 N. CENTRE ST.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 7, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park	
23d. LOCATION (City or Town) Cumberland, Md.		(County) 		(State) 	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.			ADDRESS 		25a. RECD BY REGISTRAR APR 14 1966
					25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04593

CERTIFICATE OF DEATH

04591

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, **Page 3** should be detached for use as the burial-transit permit. Then please remove carbon papers. **Pages 1 and 2** should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES J. EIRICH		First CHARLES	Middle J.
4. DATE OF DEATH APRIL 8 1966		5. LAST NAME EIRICH	Month Year Day Year APRIL 8 1966
6. SEX MALE		7. COLOR OR RACE WHITE	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. B. DATE OF BIRTH 10-3-1909		10. AGE (In years Mo. & Day) 56 yrs	11. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver		10b. KIND OF BUSINESS OR IND. & STY. Hardware Co.	11. BIRTHPLACE (County & State, or foreign country) MARYLAND-Baltimore
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME EIRICH, HENRY J.	
14. MOTHER'S MAIDEN NAME SARAH HARRISON		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes War II	
16. SOCIAL SECURITY NO		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 490x		19. INTERVAL BETWEEN ONSET AND DEATH 4 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Congestive Heart Failure		20. DUE TO 3 days	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hyperuricemia - 2 Tracy, Maryland Jan 1966 to March 66		19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 5, 1966 to April 15, 1966 , that (I) (we) lost saw the deceased alive on April 5, 1966 and that death occurred at 1966 M, from causes and on the date stated above.		22b. DATE SIGNED 4/8/66	
22a. SIGNATURE DR. G.O. HIMMELWRIGHT		22b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) DR. G.O. HIMMELWRIGHT		22d. ADDRESS 133 VIRGINIA AVE., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 11, 1966	
23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cem.		23d. LOCATION (City or Town) (County) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. ADDRESS 25b. REC'D BY REGISTRAR APR 14 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

04594

CERTIFICATE OF DEATH

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and the event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution write name and address) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROY		First W	Middle EVES
4. DATE OF DEATH Month APRIL Day 11 Year 1966	5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH 3-11-86	9. AGE (In years last birthday) 80 yrs	10. KIND OF BUSINESS OR INDUSTRY 10b. B-29 RR* EX-MAYOR	11. BIRTHPLACE (County & State or foreign country) EVANSVILLE, IND.
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME WILLIAM (D)	14. MOTHER'S MAIDEN NAME MARGARET D. (HOTSON) EVES (D)	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
16. SOCIAL SECURITY NO 70	17. INFORMANT PT'S CHART	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive myocardial infarction DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) _____ DUE TO (c) _____	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			21. I certify that (I) (this hospital) attended the deceased from 9-10 , 1957, to 4-14 , 1966, that (I) (we) last saw the deceased alive on 4-14 , 1966, and that death occurred at 8 p.m. M, from causes and on the date stated above.
22a. SIGNATURE <i>Dr. Ballin, M.D.</i>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 4-15-66
22c. PHYSICIAN'S NAME (Type) DR. BALLIN, M.D.		22d. ADDRESS 62 GREENE ST., CUMBERLAND, MARYLAND.	
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial	23b. DATE THEREOF 4/18/66	23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Cem.	23d. LOCATION (City or Town) (County) (State) Cumberland, Md.
24. FUNERAL DIRECTOR Lamie Stein Inc. Cumb. Md.	ADDRESS	25a. REC'D BY REGISTRAR DATE APR 19 1966	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 Film 3276 2/9/66 mh

04595

CERTIFICATE OF DEATH

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deceased be retained by the hospital or attending physician.

10 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

PLACE OF DEATH a. COUNTY Allegany		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN TB 12 years		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sylvan Retreat		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		d. STREET ADDRESS (Carlos)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Thursa		First Middle Fatkin		4. DATE OF DEATH April 30 1966		Month Day Year			
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 6/9/77		9. AGE (In years last birthday) 88 yrs.		IF UNDERR 1 YEAR Months	IF UNDERR 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (Country & State or foreign country) ENGLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George Adam		14. MOTHER'S MAIDEN NAME Edith Griffith		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MR. GEORGE FATKIN, 76 ORMOND ST. Address FROSTBURG, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4222 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from Jan. 2, 1955, to April 30, 1966, that (I) (we) last saw the deceased alive on April 29, 1966, and that death occurred at 4:50 AM, from causes and on the date stated above.									
22a. SIGNATURE <i>W. Mathews, M.D.</i>		22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) L. B. Mathews, M.D.		22d. ADDRESS 49 Greene St., Cumberland, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAY 2, 1966		23c. NAME OF CEMETERY OR CREMATORIAL FROSTBURG MEM. PARK		23d. LOCATION (City or Town) (County) (State) FROSTBURG MD.			
24. FUNERAL DIRECTOR HAFER FUNERAL HOME, 60 W. MAIN ST.		ADDRESS		25a. REC'D BY REGISTRAR MAY 3 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

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04596

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FROSTBURG,		c. LENGTH OF STAY IN 1b 50 YRS.		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 217 CENTER STREET		e. STREET ADDRESS 217 CENTER STREET		
3. NAME OF DECEASED (Type or print) JOHN		4. DATE OF DEATH APRIL 8th, 1966	Month Day Year	
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> JUNE 30th, 1884	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATCHMAN		10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION CO.	9. AGE (in years last birthday) 81 yrs. IF UNDER 1 YEAR Months Days Hours Mins.	
13. FATHER'S NAME WILLIAM A. FILER		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 1992		16. SOCIAL SECURITY NO. 214-03-3595	17. INFORMANT Address MISS GRACE FILER, FROSTBURG, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1992 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Carcinoma of prostate & prostatic Carcinoma of pancreas.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 3 P.M.	20f. (City or town) (County) (State) 412 N. MECHANIC ST., CYBERLAND, MD.
21. I certify that (I) (this hospital) attended the deceased from 2/10/66 to 4/8/66 , that (I) (we) last saw the deceased alive on 4/6/66 , and that death occurred at 3 P.M. from the causes and on the date stated above.		22a. SIGNATURE Walter H. Himmle		22b. DATE SIGNED 4/9/66
22c. PHYSICIAN'S NAME (Type) WALTER HIMMEL		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS 412 N. MECHANIC ST., CYBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-11-66	23c. NAME OF CEMETERY OR CREMATORIAL FIBG. MEMORIAL PARK	23d. LOCATION (City, town or county) (State) FROSTBURG, MD.
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR.,		ADDRESS FROSTBURG, MD.	25a. REC'D BY REGISTRAR APR 13 1966	25b. REGISTRAR'S SIGNATURE Charles Judge



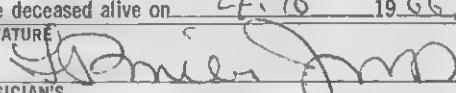
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04597

CERTIFICATE OF DEATH

04595

1
10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)	
ALLEGANY MARYLAND		a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b 4 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDLOTHIAN	
3. NAME OF DECEASED (Type or print)		First BEULAH	Middle M.
4. DATE OF DEATH		Month APRIL	Day 10
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
FEMALE		WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (in years last birthday)	
JUNE 14, 1906		59	years
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS HENDERSHOT		14. MOTHER'S MAIDEN NAME ANNA RALSTON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address JAMES L. FINZEL, MIDLOTHIAN, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 4 days	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		Arteriosclerotic CV disease years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4-7, 1966, to 4-10, 1966, that (I) (we) last saw the deceased alive on 4-10, 1966, and that death occurred at 3 p.m. from the causes and on the date stated above.		22b. DATE SIGNED 4-11-66	
22a. SIGNATURE 		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) LESLIE R. MILES, M. D.		22d. ADDRESS LONACONING, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-12-66	23c. NAME OF CEMETERY OR CREMATORIUM UNION GROVE CEMETERY
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.		25a. REC'D BY REGISTRAR APR 13 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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FOR STATE
HEALTH DEPT M

04598

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04596

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Page 3 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and event within 72 hours after death.

PLACE OF DEATH		2 USUAL RESIDENCE (Where deceased lived, if inst. not on Res. before admission)	
a. COUNTY Allegany		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cumberland		b. COUNTY Allegany	
c. LENGTH OF STAY IN lb 58 years		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Oak Street		d. STREET ADDRESS Oak Street	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John		First Middle Henry	4 DATE OF DEATH Apr. 24 1966
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED
8. DATE OF BIRTH July 28, 1907		9. AGE (In years lost birthday) 58 yrs	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman		10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (State or foreign country) Cumberland, Md.
13. FATHER'S NAME John Grimm		14. MOTHER'S MAIDEN NAME Ida Grady	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service no		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Wm. J. Atkinson, Cumberland, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		Coronary	Occlusion
		DUE TO (b)	Coronary Sclerosis
		DUE TO (c)	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cor-Pulmonale---Pulmonary Emphysema, Marked		19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED Apr. 24, 1966			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 27, 1966	23c. NAME OF CEMETERY OR CREMATORIAL PARK Sunset Memorial Park
23d. LOCATION (City or Town) Cumberland, Md.		(County) (State)	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25. REGISTRATION DATE APR 26 1966	26. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04599

CERTIFICATE OF DEATH

04597

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
a. COUNTY ALLEGANY		a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 1 Day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
e. STREET ADDRESS 214 MASSACHUSETTS AVE.		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY		4. DATE OF DEATH Month APRIL Day 12 Year 1966	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED X NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 2-29-20	
9. AGE (In years last birthday) 46 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee of Pgh Plate Glass Company		11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Henry Coleman	
14. MOTHER'S MAIDEN NAME Grace Butler		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 219-03-9420		17. INFORMANT PT'S CHART	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO stating the underlying cause (c)		Cerebrovascular Accident (Hemorrhage.) 3 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-12 , 19 66 , to 4-12 , 19 66 that (I) (we) last saw the deceased alive on 4-12 , 19 66 , and that death occurred at 6:00 P.M. from causes and on the date stated above.		22b. DATE SIGNED 4-13-66	
22a. SIGNATURE <i>DR. J. G. S. SPIGGLE</i>		22c. ATTENDING M.D. PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. ADDRESS Smallwood St., CUMBERLAND, MARYLAND		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE THEREOF 4/15/66		23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park	
24. FUNERAL DIRECTOR Ruth E. Silcox		25a. ADDRESS Cumberland Maryland 21502	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. RFCD BY REGISTRAR DATE APR 18 1966	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04600

04598

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Coralville		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Coralville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Oscar Buntin Floegle		First Oscar	Middle Buntin	Last Floegle	4. DATE OF DEATH Month April Day 19 Year 1966
S SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 27, 1908		9. AGE (In years lost birthday) 60 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Coralville, Md.	
13. FATHER'S NAME David Floegle		14. MOTHER'S MAIDEN NAME Laura Shatzer		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-10-0000		17. INFORMANT Mrs. O. Buntin Fl. gle, Coralville	
18. ADDRESS					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Undifferentiated Carcinoma					
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Rt. Lung with Metas.				3 mos.?	
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) (Post-Biopsy by Dr. Hadidian - Feb. 66)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING CAUSE OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) La Vale, Md. (County) Carroll (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from 5/6/65 to 2/8/66 , that (I) (we) last saw the deceased alive on 2/8/66 , and that death occurred at 5 A.M. from the causes and on the date stated above.				22b. DATE SIGNATURE 1/17/66	
22a. SIGNATURE Thomas F. Lushy		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNATURE 1/17/66	
22c. PHYSICIAN'S NAME (Type) 932 National Highway La Vale, Md. - 21504					
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 9, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Rest Land Mem. Gardens, Carroll, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Harvey W. Feagles, Esq., La.		ADDRESS		25a. REC'D BY REGISTRAR APR 11 1966	
				25b. DIRECTOR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04601

CERTIFICATE OF DEATH

04599

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
ALLEGANY MARYLAND		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b 5 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. SAVAGE	
3. NAME OF DECEASED (Type or print)		First CHARLES	Middle G.
4. DATE OF DEATH		Month APRIL	Day 19
5. SEX		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years last birthday) 72 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED TRUCKER		10b. KIND OF BUSINESS OR INDUSTRY KELLY-SPFD. TIRE CO.	11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME THOS. L. FRANKENBERRY	
14. MOTHER'S MAIDEN NAME DARHTA MILLER		15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO.	
17. INFORMANT		Address RAY E. FRANKENBERRY, CRESAPTOWN, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		4/10/1966 Myocardial infarction due to coronary thrombosis 20 seconds	
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b). DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Severe Pulmonary insufficiency due to Pulmonary		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug.</u> , 19 <u>62</u> , to <u>4/19</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/19</u> , 19 <u>66</u> , and that death occurred at <u>7:15 P.M.</u> from the causes and on the date stated above.		22b. DATE SIGNED <u>4/20/66</u>	
22a. SIGNATURE <u>Martin Rothstein</u>		22b. DATE SIGNED <u>4/20/66</u>	
22c. PHYSICIAN'S NAME (Type) MARTIN ROTHSTEIN, M. D.		22d. ADDRESS 48 BROADWAY, FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-22-1966	
23c. NAME OF CEMETERY OR CREMATORIUM METHODIST CEMETERY		23d. LOCATION (City, town or county) MT. SAVAGE, MD.	
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.		25a. REC'D BY REGISTRAR APR 22 1966	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04602

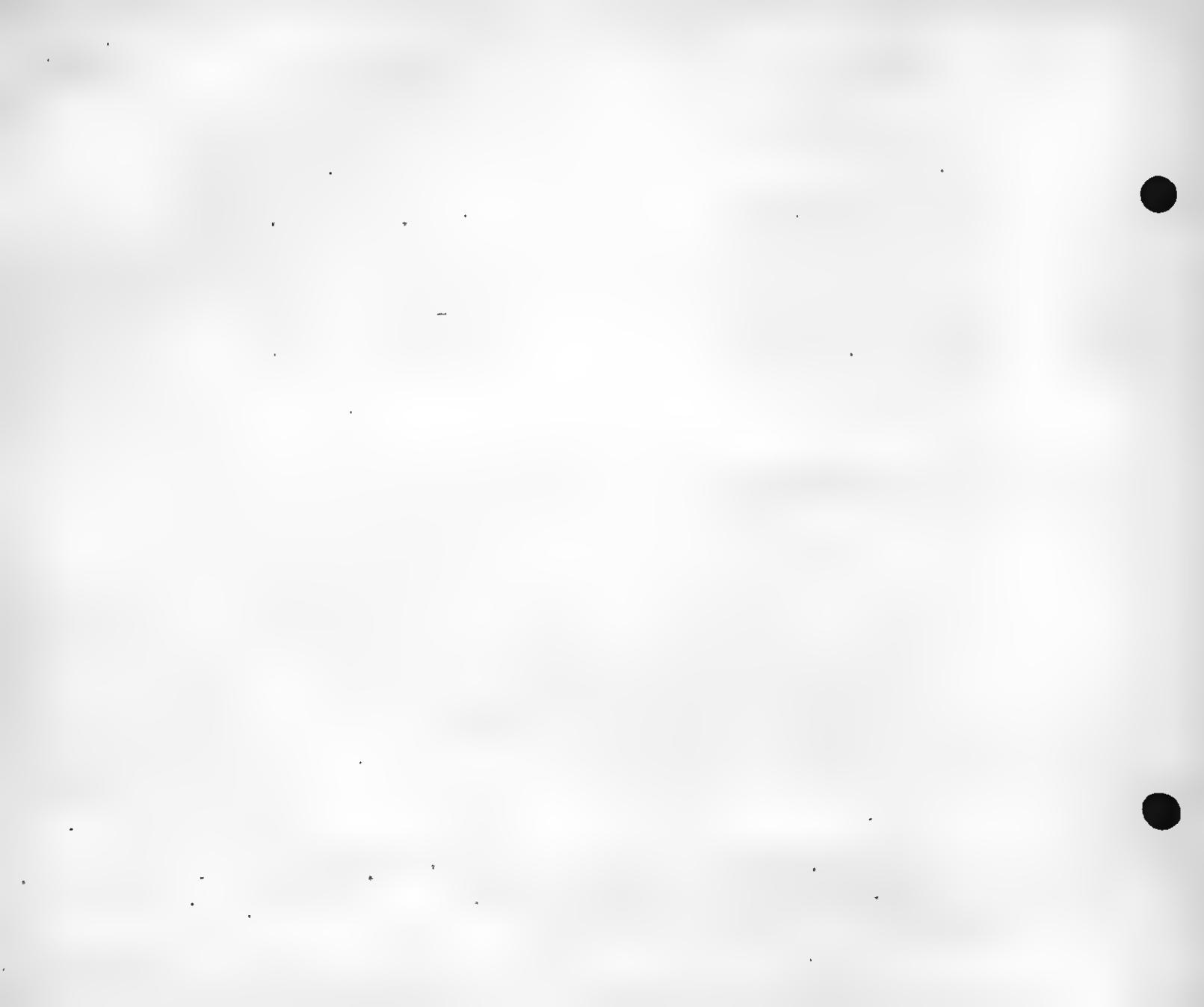
CERTIFICATE OF DEATH

04600

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE b. COUNTY	
ALLEGHANY MARYLAND		MARYLAND ALLEGHANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
CUMBERLAND		CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
SCARED HEART HOSPITAL		123 N. CENTRE ST.	
3. NAME OF DECEASED (Type or print)		First	Middle
ALBERTHA		L.	FRANTZ
4. DATE OF DEATH		Month	Day Year
h 22 19 66			
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
FEMALE WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Housewife		CUMBERLAND MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
PERRY DEETZ		JANE CESSNA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
No		17. INFORMANT	
		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		HEART FAILURE	
4200 Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.		CONGESTIVE	
DUE TO (b)		ARTERIO SCLEROTIC HEART DISEASE	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
FRACTURE LEFT HIP			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____, M, from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE		22b. DATE SIGNED	
DR. MICHAL GLICK		4-22-66	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
Burial 4/25/66		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
Louis Stein Inc - Cumb. Md.		APR 27 1966 g Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04604

CERTIFICATE OF DEATH

04604

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician. Page 4 may be retained by the hospital or attending physician. Director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Allegany					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 5 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		d. STREET ADDRESS 19 Linden Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Josephine C Glorius		First	Middle	Last	4. DATE OF DEATH April 16 1966	Month	Day	Year	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 10/21/04		9. AGE (In years last birthday) 61 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Allegany Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Frank Dailey		14. MOTHER'S MAIDEN NAME Margaret Flahagan		15. ADDRESS					
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		17. SOCIAL SECURITY NO		18. INFORMANT					
				Chart					
19. MEDICAL CERTIFICATION		20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 5271 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) PULMONARY EMPHYSEMA DUE TO (c)		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		22. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
				19 19 66		19 19 66			
21. I certify that (I) (this hospital) attended the deceased from JAN 1966 to 4-16 1966 , that (I) (we) last saw the deceased alive on 4-16 1966 , and that death occurred at 4:50 PM , from causes and on the date stated above.									
22a. SIGNATURE <i>Michael Glick</i>		22b. DATE SIGNED 4-19-66		22c. PHYSICIAN'S NAME (Type) Dr. Glick & Spiggle		22d. ADDRESS 126 N Smallwood Street			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-19-66		23c. NAME OF CEMETERY OR CREMATORIAL ST. MICHAEL'S CEMETERY		23d. LOCATION (City or Town) FROSTBURG, MD.		23e. (County) (State)	
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.		ADDRESS		25a. REC'D BY REGISTRAR APR 21 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04605

CERTIFICATE OF DEATH

114603

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURA and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 89 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURA and give nearest town) CUMBERLAND	
3. NAME OF DECEASED (Type or print) GEORGE		First E.	Middle GRAY
4. DATE OF DEATH Month APRIL	Day 3	Year 1966	5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
6. SEX MALE	7. COLOR OR RACE WHITE	8. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH March 28, 1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Antique Dealer-Own	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.	12. CITIZEN OF WHAT COUNTRY USA
13. FATHER'S NAME GEORGE GRAY	14. MOTHER'S MAIDEN NAME ANNA GONSO	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Eugene Mason, Cumberland, Md.	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adam-Stokes Syndrome		19. INTERVAL BETWEEN ONSET AND DEATH Hours	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Cardiac Arrest			
DUE TO DUE TO DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from 1959 , 19, to 1966 , 19, that (I) (we) last saw the deceased alive on 4/3/66 , 19, and that death occurred at 8:27 AM causes and on the date stated above.		20f. (City or town) (County) (State)	
22a. SIGNATURE <i>Overton Himmelwright</i>		22b. DATE SIGNED 4/4/66	
22c. PHYSICIAN'S NAME (Type) DR. GVERTON HIMMELWRIGHT		22d. ADDRESS 133 VIRGINIA AVE. CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Apr. 6, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Camp Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Paw Paw, W. Va.
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR APR 12 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04606

CERTIFICATE OF DEATH

04604

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 7 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
f. STREET ADDRESS 123 S. SMALLWOOD ST.,		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) THEODORE		First WALTER	Middle HAENFTLING
4. DATE OF DEATH APRIL 1, 1966.		5. SEX MALE	6. COLOR OR RACE WHITE
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. B. DATE OF BIRTH 6-11-1903	9. AGE (In years last birthday) 62 yrs
10. a. USUAL OCCUPATION (G ve kind of work done during most of working life, even if retired) Machinist Helper		10b. KIND OF BUSINESS OR INDUSTRY B & O Rwy.	11. BIRTHPLACE (County & State, or foreign country) GARRETT, PA.
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME GILBERT E. HAENFTLING	
14. MOTHER'S MAIDEN NAME EMMA APPEL		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service No,	
16. SOCIAL SECURITY NO		17. INFORMANT Mrs. Catherine Haenftling Smallwood MEMORIAL HOSPITAL - CUMBERLAND, MD. ST.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 2374 DUE TO Fracture of brain, right, frontal lobe INTERVAL BETWEEN ONSET AND DEATH 6 wks		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Arterosclerosis DUE TO Arteriosclerosis of abd. aorta ONSET AND DEATH under (c) Hypertension Heart Disease	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterosclerosis Heart Disease		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 1964	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1964
21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 4/1/1966 , and that death occurred at 2:10 P.M. , 19 1966 , that (I) (we) last cause and on the date stated above.		20f. (City or town) 1964 (County) 1964 (State) 1964	
22a. SIGNATURE Alverson		M.D. <input type="checkbox"/> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 4/2/66
22c. PHYSICIAN'S NAME (Type) DR. S. G. WEISMAN		22d. ADDRESS 59 GREENE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/4/66	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Sunset Memorial Park
24. FUNERAL DIRECTOR H. Wayne George		25a. REC'D BY REGISTRAR APR 5 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04607

CERTIFICATE OF DEATH

04615

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN b 21 DAYS		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE WEST VIRGINIA		b. COUNTY HAMPSHIRE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. STREET ADDRESS RT. #6				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First GERTIE	Middle G.	Last HAINES	4 DATE OF DEATH Month APRIL	Month 5	Day 19	Year 66		
5 SEX FEMALE	6 COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 18, 1897	9. AGE (in years birthday) 88 yrs	10. UNDER 1 YEAR Months 0	11. UNDER 24 HRS. Days 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT USA?			
13. FATHER'S NAME JOHN R. GLAZE		14. MOTHER'S MAIDEN NAME AMANDA MAE TEETER							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Chronic Pyelonephritis with Urinary		with disease		INTERVAL BETWEEN ONSET AND DEATH about 20 hours			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) 45-66		20f. (City or town) (County) (State) 45-66			
21. I certify that (I) (this hospital) attended the deceased from 3-15-66 , 14:25 p.m., 1966, that (I) (we) last saw the deceased alive on 19-66 , and that death occurred at 45-66 , from causes and on the date stated above.									
22a. SIGNATURE Howard L. Tolson		22b. DATE SIGNED 4-5-66							
22c. PHYSICIAN'S NAME (Type) DR. HOWARD L. TOLSON		22d. ADDRESS 122 S. CENTRE ST. CUMB. MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF April 8		23c. NAME OF CEMETERY OR CREMATORIAL Forest Glenn		23d. LOCATION (City or Town) (County) (State) Greenspring Hamp. W. Va.			
24. FUNERAL DIRECTOR Dale L. Merritt		ADDRESS 404 Decatur Street Cumberland, Maryland		25a. REC'D BY REGISTRAR APR 7 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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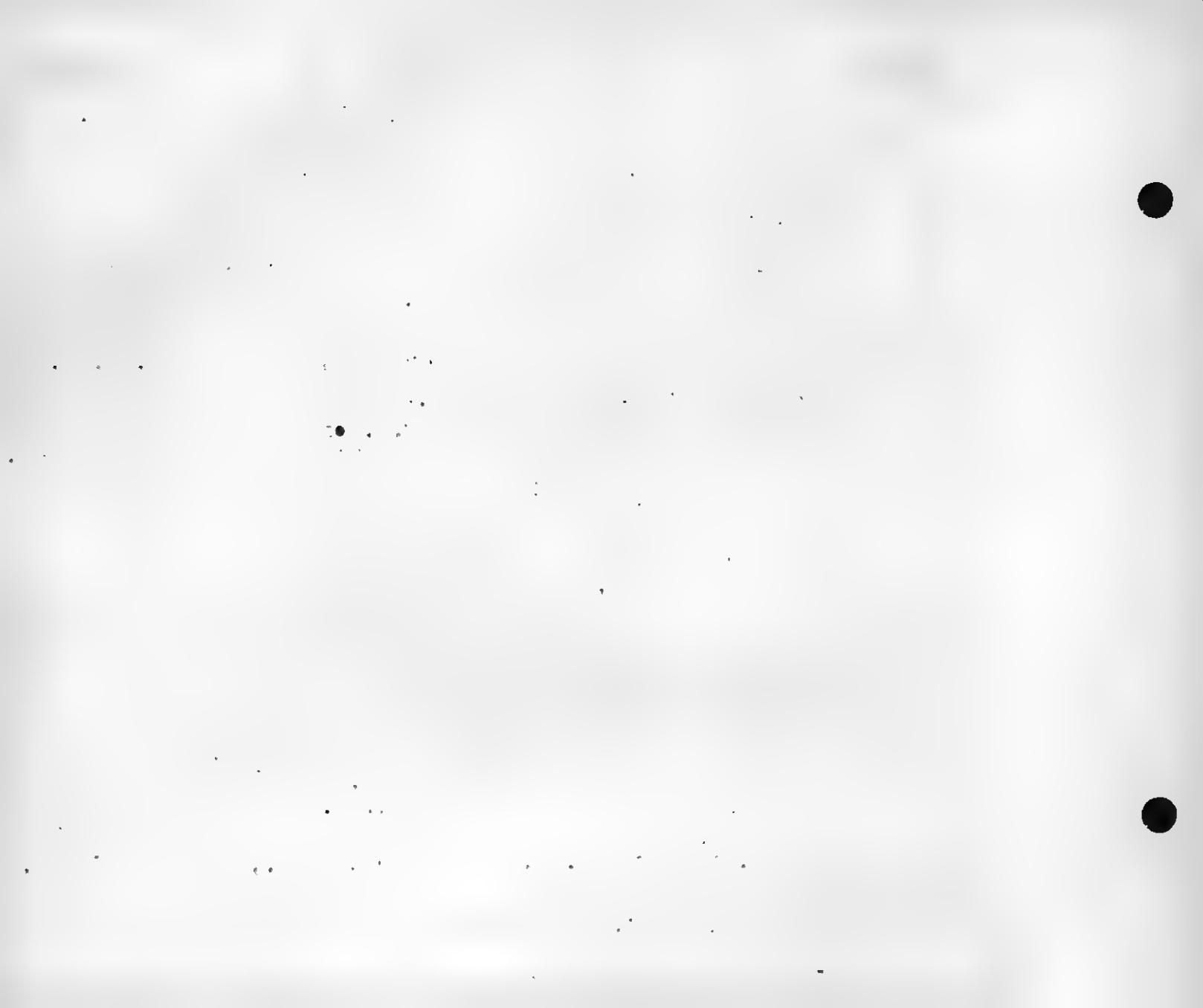
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04608

04606

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY	Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	C. LENGTH OF STAY IN 1b			a. STATE Maryland	b. COUNTY Allegany		
Cumberland	4/29/1964			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				Cumberland			
Allegany County Infirmary				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print)	First Mary	Middle Ellen	Last Heier	4. DATE OF DEATH April 29, 1966	Month April	Day 29, 1966	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/27/1886	9. AGE (in years last birthday) 80 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Own Home		Westernport, Maryland		U. S. A.	
13. FATHER'S NAME James Henry Cavey				14. MOTHER'S MAIDEN NAME Rosie Belle Clapp			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT P.O. Box 599 Address Cumberland, Md Allegany County Infirmary records.			
None							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertension, char. degenerativa</i> 260X DUE TO <i>Arteriosclerosis, Secundaria</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Diabetes Mellitus</i> (c) <i>Drually leg occupatralis</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
MEDICAL CERTIFICATION							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)	20f. (City or town) Cumberland	(County) Md.	(State)	
21. I certify that (I) (this hospital) attended the deceased from 4/29/64, 19, to 4/29/66, 19, that (I) (we) last saw the deceased alive on 4/29/66, 19, and that death occurred at A. M., from the causes and on the date stated above.	22a. SIGNATOR <i>Lee B. Mathews</i>						
	at 11:30 A. M. ATTENDING M.D. <input checked="" type="checkbox"/> MED. PHYS. <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 4/30/1966						
22c. PHYSICIAN'S NAME (Type) Lee B. Mathews, M. D.	22d. ADDRESS 49 Greene St., Cumberland, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 2, 1966	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS St. Mary Cemetery	23d. LOCATION (City, town or county) Cumberland, Md.				
24. FUNERAL DIRECTOR Byron Kight	25a. REC'D BY REGISTRAR MAY 3 1966						
	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						



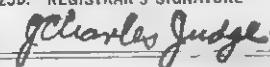
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04609

CERTIFICATE OF DEATH

04608

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 40 YEARS											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 800 BEDFORD STREET		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND											
3. NAME OF DECEASED (Type or print) MARY		First J.	Middle HINZE	4. DATE OF DEATH APRIL 27	Month 1966	Day 19	Year 66						
5. SEX FEMALE		6. GOLD OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH OCT 19 1906	9. AGE (In years last birthday) 59 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF HOURS Hours 0					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOL TEACHER		10b. KIND OF BUSINESS OR INDUSTRY COUNTY SCHOOLS		11. BIRTHPLACE (County & State, or foreign country) WABASH, INDIANA		12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME FRANK SOWERBY		14. MOTHER'S MAIDEN NAME BERTHA WHITE		Address CUMBERLAND, MD.									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 216 22 7136		17. INFORMANT H. FRANK HINZE		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Reticulum Cell Sarcoma with generalized metastases			19. INTERVAL BETWEEN ONSET AND DEATH 6 years				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Ex. C.O.C.		DUE TO (b) 		DUE TO (c) 									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
22a. SIGNATURE 		22b. DATE SIGNED 4-30-66		22c. PHYSICIAN'S NAME (Type) WYAND F. DOERNER, M.D.					22d. ADDRESS 414 N. MECHANIC ST. CUMBERLAND, MD.	23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF APRIL 30, 1966	23c. NAME OF CEMETERY OR CREMATORIUM HILLCREST CEMETERY	23d. LOCATION (City, town or county) (State) CUMBERLAND, MD.
24. FUNERAL DIRECTOR BYRON MIGHT		ADDRESS CUMBERLAND, MD.		25a. REC'D BY REGISTRAR DA					25b. REGISTRAR'S SIGNATURE 				
VR A15 (4) 20M 1/65				DA MAY 3 1966									



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04610

CERTIFICATE OF DEATH

04610

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		b. COUNTY Allegany				
c. LENGTH OF STAY IN lb 79 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 244 North Mechanic St.		d. STREET ADDRESS 244 North Mechanic St.				
3. NAME OF DECEASED (Type or print) Caroline		First Caroline	Middle Angela			
Last Holmes		4. DATE OF DEATH April	Month Day Year 29 19 66			
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH August 8, 1886		9. AGE (In years last birthday) 79	10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (County & State, or foreign country) Cumberland, Md.			
13. FATHER'S NAME Joseph T. Matt		14. MOTHER'S MAIDEN NAME Anna Lafferty				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 	17. INFORMANT Joseph P. & Dorothy L. Holmes, Cumberland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>481X</i> Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. influenza		INTERVAL BETWEEN ONSET AND DEATH 				
DUE TO (b) CVA						
DUE TO (c) cerebral arteriosclerosis						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1958	20f. (City or town) 4/29/66	(County) 	(State)
21. I certify that (I) (this hospital) attended the deceased from 1958 , 19, to 4/29/66 , that (I) (we) last saw the deceased alive on 4/25/66 and that death occurred at M , from the causes and on the date stated above.						
22a. SIGNATURE <i>Elizabeth Brings</i>		22b. DATE SIGNED 4/29/66				
22c. PHYSICIAN'S NAME (Type) Dr. Elizabeth G. Brings, M.D.		22d. ADDRESS 55 Greene St., Cumberland, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 2, 1966	23c. NAME OF CEMETERY OR CREMATORIAL SS. Peter & Paul Cemetery	23d. LOCATION (City, town or county) Cumberland, Md.	(State) 	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS		25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE MAY 3 1966	





MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04611

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04611

1. PLACE OF DEATH
 a. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Memorial Hospital

3. NAME OF
 DECEASED
 (Type or print)

First
 EFFIE

Middle
 MAY

Last
 HOLTZMAN

4. DATE
 OF
 DEATH
 April 11, 1966

5. SEX
 Female

6. COLOR OR RACE
 White

7. MARRIED
 WIDOWED

NEVER MARRIED

DIVORCED

8. DATE OF BIRTH
 August 26, 1874

9. AGE (In years
 last birthday)
 91 yrs.

10. IF UNDER 1 YEAR
 Months

11. IF UNDER 24 HRS.
 Days
 Hours
 Min.

10a. USUAL OCCUPATION (Give kind of work done
 during most of working life, even if retired)

1b. KIND OF BUSINESS OR
 INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT
 COUNTRY
 U.S.A.

13. FATHER'S NAME
 Charles Swan Wilson

14. MOTHER'S MAIDEN NAME
 Cornelius Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
 (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT
 None

Address

Leonard E. Holtzman Cumberland, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (e)

Chronic Myocarditis

INTERVAL BETWEEN
 ONSET AND DEATH
 Months

421
 Conditions, If any, which
 gave rise to immediate
 cause (a), stating the
 underlying cause last.

DUE TO
 (b)

Arteriosclerotic Cardiovascular
 disease

DUE TO
 (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Fracture right Hip

19. WAS AUTOPSY
 PERFORMED?
 YES NO

20a. EXTERNAL CAUSE WAS
 PRIMARY or CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Fell at home in Kitchen

20c. TIME OF INJURY Month, Day, Year
 Hour a.m. 7:00 a.m.
 p.m. 4/7/1966

20d. INJURY OCCURRED While
 at work Not White
 at work

20e. PLACE OF INJURY (Home, farm,
 factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

Cumberland, Alleg. Md.

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry and in my opinion
 death resulted from: Natural causes Accident , Suicide , Homicide , Undetermined manner

ACTUAL
 SIGNATURE

Benedict Skitarelic

CHIEF MEDICAL EXAMINER
 M.D. ASSISTANT MEDICAL EXAMINER

22. DATE SIGNED

DEPUTY MEDICAL EXAMINER April 14, 1966
 Address (Street, city, town, or county) Cumberland, Md.

23a. BURIAL, CREMATION, DATE THEREOF
 REMOVAL (Specify)

23c. NAME OF CEMETERY OR CREMATORIAL
 ADDRESS

23d. LOCATION (City, town or county)
 (State)

Burial 4/17/66

Rose Hill Cemetery

Cumberland, Maryland

24. FUNERAL DIRECTOR

Philip H. Gould 121 Mem. Ave. Cumb. Md.

25a. REGD. BY REGISTRAR APR 18 1966
 DATE

25b. REGISTRAR'S SIGNATURE
 Charles Judge

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and to any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

04612

CERTIFICATE OF DEATH

04611

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b 26 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RICHARD		First J.	Middle HOPKINS
4. DATE OF DEATH APRIL 27, 1966	Month	Day	Year
5. SEX MALE	6. COLOR DR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH MAR. 23, 1908
9. AGE (in years less birthday) 58 yrs	10. KIND OF BUSINESS DR INDUSTRY REFRACTORY	11. BIRTHPLACE (County & State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME RICHARD HOPKINS	14. MOTHER'S MAIDEN NAME eva dickey	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16. SOCIAL SECURITY NO. 213-10-9108	17. INFORMANT MRS. ELEANOR HOPKINS, RT. 2, FROSTBURG, MD.	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Bronchial asthma DUE TO (c)		INTERVAL BETWEEN ONCE DEATH two years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour: a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Mar 25, 1966 to Apr 27, 1966 , that (I) (we) last saw the deceased alive on Apr 27, 1966 , and that death occurred at 200 M, from causes and on the date stated above.			
22a. SIGNATURE W. O. McLane		22b. DATE SIGNED Apr 29, 1966	
22c. PHYSICIAN'S NAME (Type) W. O. McLane, M. D.		22d. ADDRESS E. MAIN ST., FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-30-1966	23c. NAME OF CEMETERY OR CREMATORIAL FBIG. MEMORIAL PARK
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.		23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.	
ADDRESS		25a. RECEIVED BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge
DATE MAY 2 1966		DATE MAY 2 1966	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04613

CERTIFICATE OF DEATH

Reg. Dist. No.

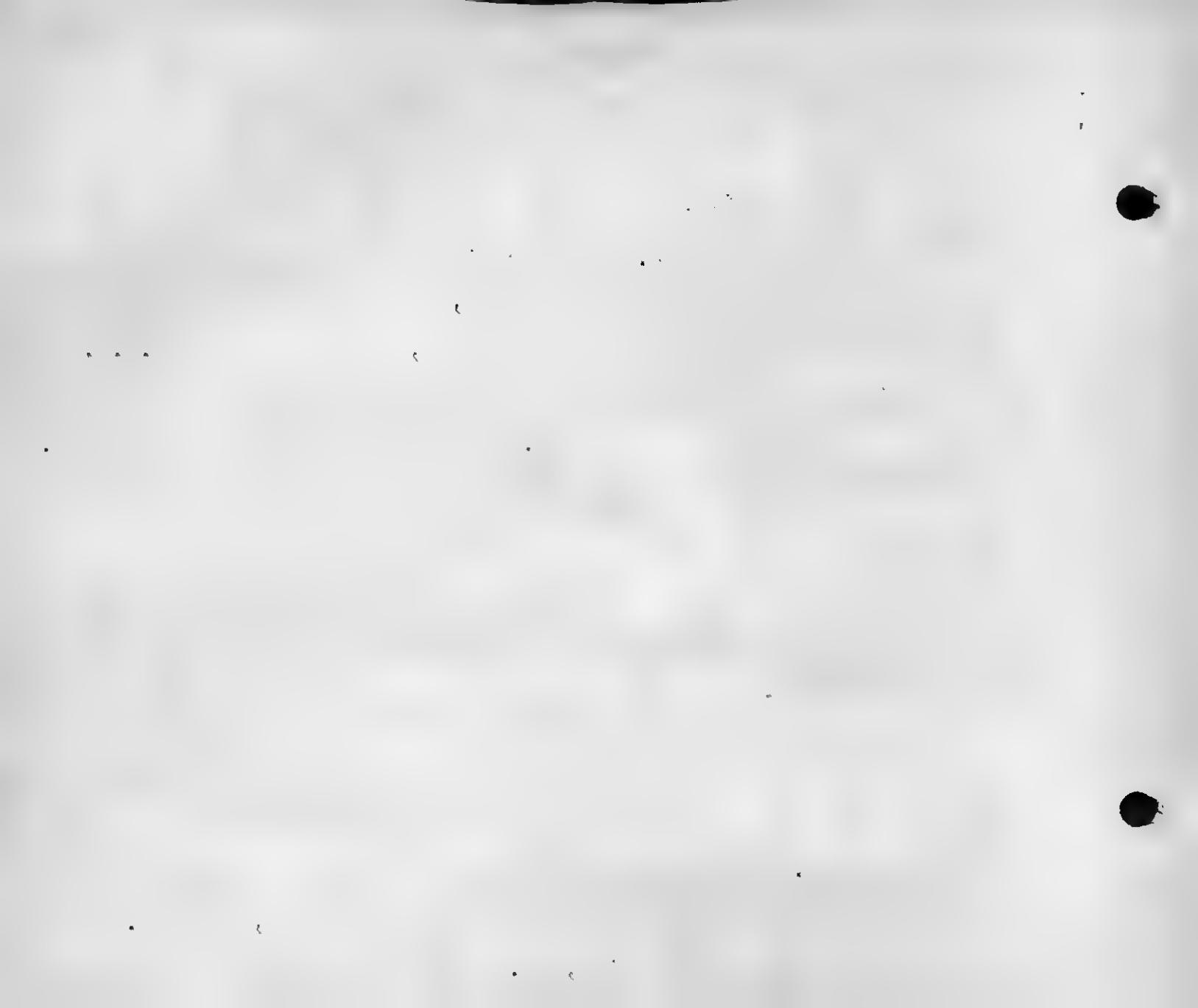
04612

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with
 page 3 should be checked for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

I

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		d. STREET ADDRESS Douglas Avenue	
3. NAME OF DECEASED (Type or print) James J. Hotchkiss		First James	Middle J.
4. DATE OF DEATH April 1 1966	Month April	Day 1	Year 1966
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 7, 1907
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Railroad Employee		10b. KIND OF BUSINESS OR INDUSTRY Midland, Maryland	
11. BIRTHPLACE (State or foreign country) Midland, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Hotchkiss		14. MOTHER'S MAIDEN NAME Elizabeth Shearer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO. Mrs. Margaret Hotchkiss	
17. INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Uremia ; Terminal Bronchogenic Carcinoma, with Regional & distant metastasis	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 15 months.	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Frostburg, Md.		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 16, 1966 , to April 1, 1966 , that I last saw the deceased alive on April 1, 1966 , and that death occurred at 11:00 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Alvin J. Walters</i>		ADDRESS (Street, city or town, state) 48 Broadway	
PHYSICIAN'S NAME (Type) Alvin J. Walters		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/4/66	
22c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		22d. LOCATION (City, town, or county) Moscow, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, Md.	
24a. REC'D BY REGISTRAR APR 5 1966		24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04614

CERTIFICATE OF DEATH

04613

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		b. COUNTY ALLEGANY	
c. LENGTH OF STAY IN 1b 7 HRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 821 BRADDOCK RD.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LLOYD		First HUMBERTSON	Middle Last HUMBERTSON
4. DATE OF DEATH APRIL 5 1966		Month APRIL	Day 5
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
8. B. DATE OF BIRTH 5-15-1900		9. AGE (In years last birthday) 65 yrs.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Special Clerk-Celanese Corp		11. BIRTHPLACE (County & State, or foreign country) PENNA. SOMERSET CO.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME EDWIN HUMBERTSON		14. MOTHER'S MAIDEN NAME LILLY CUSTER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4231 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		INTERVAL BETWEEN ONSET AND DEATH 78 hrs.	
(b) DUE TO Heart attack			
(c) DUE TO Stroke			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumbe
20f. (City or town) Cumbe		(County) Alleg. (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from 4/4/66 to 4/5/66 , 19, that (I) (we) lost saw the deceased alive on 4/5/66 , 19, and that death occurred at 2:18 AM from causes and on the date stated above.		22b. DATE SIGNED 4/5/66	
22a. SIGNATURE R. J. Williams		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22b. DATE SIGNED 4/5/66
22c. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS		22d. ADDRESS 122 S. CENTRE ST.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 7, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park
23d. LOCATION (City or Town) Near Cumberland, Alleg. Md.		(County) Alleg. (State) Md.	
24. FUNERAL DIRECTOR John J. Hafer		25a. ADDRESS 230 Balto Ave., Cumberland, Md.	25b. RECD BY REGISTRAR APR 12 1966
		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

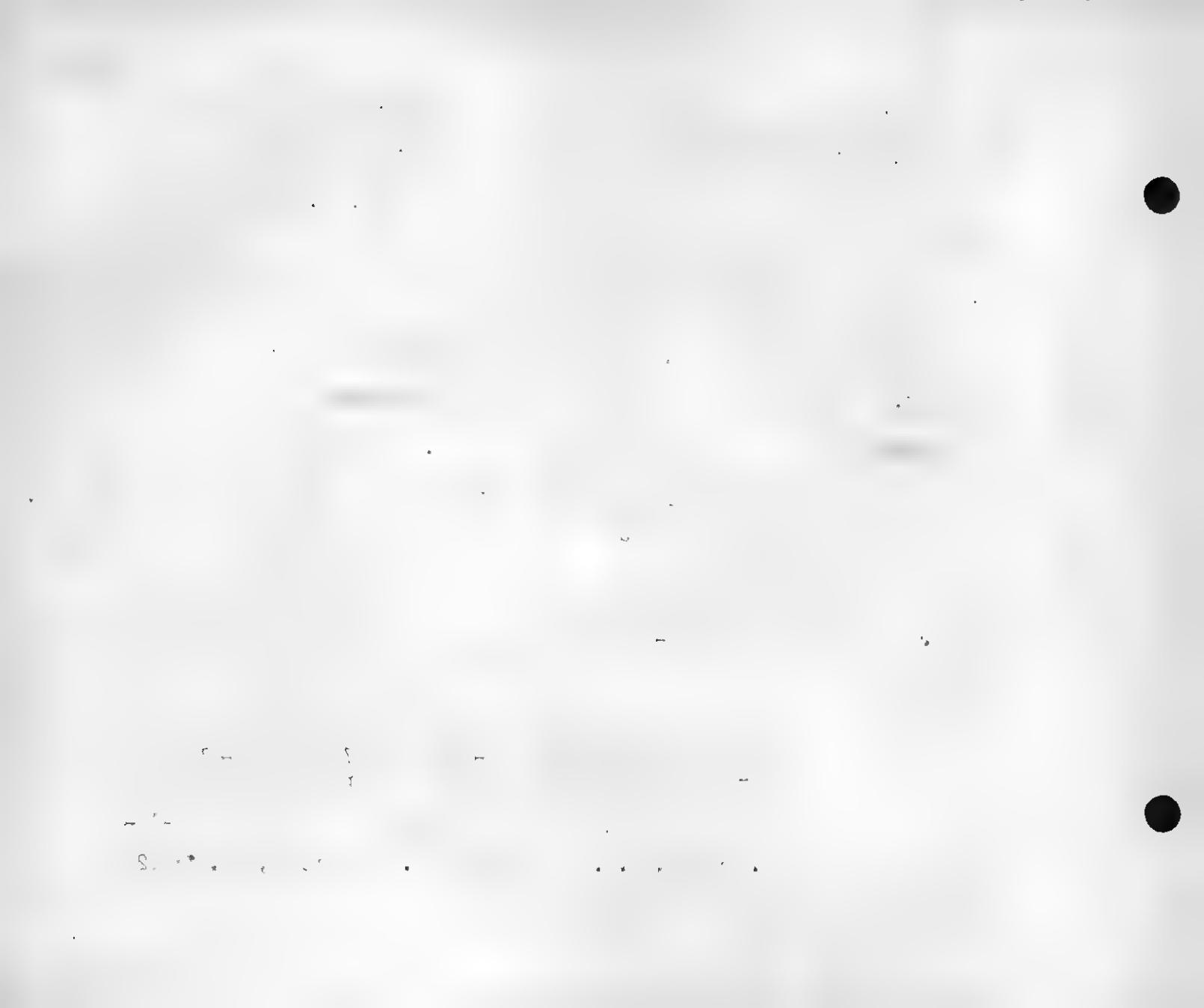
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04615

CERTIFICATE OF DEATH

04615

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Jackson David	First Jackson	Middle M	Last Jackson
4. DATE OF DEATH April 17 1966	Month April	Day 17	Year 1966
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH October 15, 1892
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cost Accountant - Kelly S. Tire Co.		10b. KIND OF BUSINESS OR INDUSTRY Cost Accountant - Kelly S. Tire Co.	
11. BIRTHPLACE (County & State, or foreign country) Granville, New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William J. Jobson		14. MOTHER'S MAIDEN NAME Elizabeth Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 214-07-0512	17. INFORMANT Address pt. chart
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left ventricular failure			
4:1X DUE TO Influenza			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic cardio-vascular disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5 - 17 , 1957, to 4 - 17 , 1966, that (I) (we) last saw the deceased alive on 4 - 17 , 1966, and that death occurred at 4 p.m. from the causes and on the date stated above.		22b. DATE SIGNED 4-18-66	
22a. SIGNATURE <i>Ralph W. Ballin</i>		22c. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) Ralph W. Ballin, M.D.		22d. ADDRESS 62 Greene St., Cumberland, Md. 21502	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/21/66	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Sunset Memorial Park
24. FUNERAL DIRECTOR Ruth E. Silcox		25a. REC'D BY REGISTRAR APR 20 1966	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04616

CERTIFICATE OF DEATH

04616

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, within 72 hours after death.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
a. COUNTY Alleghany		a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 67 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 101 Park Street		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
3. NAME OF DECEASED (Type or print) Justina Mae Kelly		d. STREET ADDRESS 101 Park Street	
4. DATE OF DEATH Apr. 4 1966		Month	Day
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
8. DATE OF BIRTH March 30, 1899		9. AGE (In years last birthday) 67 yrs.	10. IF UNDER 1 YEAR Months
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (County & State, or foreign country) Cumberland, Md.
13. FATHER'S NAME Harry Howard		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 	17. INFORMANT Mr. John C. Kelly, Cumberland, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE LEFT VENTRICULAR FAILURE 4-7-66 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. Mitral Insufficiency Cholesterolosis		INTERVAL BETWEEN ONSET AND DEATH SUDEN	
(b) CORONARY ARTERIOSCLEROSIS AND DUE TO (c) MYOCARDIAL FIBROSIS		4 yrs?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work Not While at work 	20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)
20f. (City or town) 		(County) 	
		(State) 	
21. I certify that (I) (this hospital) attended the deceased from MARCH 16 1966 to APRIL 4 1966 , that (I) (we) last saw the deceased alive on MARCH 15 1966 , and that death occurred at 9A M , from the causes and on the date stated above.		22b. DATE SIGNED 4-7-66	
22a. SIGNATURE Samuel M. Jacobson		M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Sr. Samuel M. Jacobson, MD		22d. ADDRESS 50 Pershing St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 7, 1966	23c. NAME OF CEMETERY OR CREMATORIUM Greenmount Cemetery
23d. LOCATION (City, town or county) Cumberland, Md.		(State) 	
24. FUNERAL DIRECTOR James F. Scarnelli, Cumberland, Md.		25a. REC'D BY REGISTRAR APR 12 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



2
1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

2 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and kept on file for 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04617 04617

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barton		b. COUNTY Allegany	
c. LENGTH OF STAY IN 1b 64 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barton	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Richard Earl Keyes		4. DATE OF DEATH April 16, 1966	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer		10b. KIND OF BUSINESS OR INDUSTRY Self-Employed	8. DATE OF BIRTH Feb. 24, 1902
10c. BIRTHPLACE (County & State, or foreign country) Maryland		9. AGE (In years last birthday) 64 yrs	11. BIRTHPLACE (County & State, or foreign country) Maryland
13. FATHER'S NAME Richard E. Keyes		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-11-1111	17. INFORMANT Mrs. Elsie Keyes
			Address Barton, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 111X Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day Pulmonary emphysema 15 years	
DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Congestive heart failure			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED while <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb. 1966 to 4/18/66 , that (I) (we) last saw the deceased alive on 4/18/66 , and that death occurred at 2 A.M. from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE William W. Lesh		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) William W. Lesh, MD		22d. ADDRESS Main St. Westernport, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/18/66	23c. NAME OF CEMETERY OR CREMATORIAL Laurel Hill Cemetery
24. FUNERAL DIRECTOR E. J. Beck		25a. ADDRESS Westernport, Maryland	23d. LOCATION (City, town or county) Moscow Mills, Md.
		25a. REC'D BY REGISTRAR APR 19 1966	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04618

CERTIFICATE OF DEATH

04618

George 1 M 1 H 1
10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 19 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 436 N. CENTER ST.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Mary Middle Martha Last Keyser	4. DATE OF DEATH 4	Month 9	Day 19	Year 66	
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 11-2-1897	9. AGE (In years last birthday) 68 yrs	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (County & State, or foreign country) Eckhart, Md.	
13. FATHER'S NAME JOHN STEWART			14. MOTHER'S MAIDEN NAME SARAH BONE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO None		17. INFORMANT Mr. Olin D. Keyser Address 436 N. centre St. Cumb, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) <i>Edema of abdomen</i>			INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-21-1966 to 4-9-66 that (I) (we) last saw the deceased alive on 4-8-1966 and that death occurred at 6:00 A.M. from causes and on the date stated above.					
22a. SIGNATURE <i>B. Schindler</i>		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-9-66	
22c. PHYSICIAN'S NAME (Type) B. SCHINDLER		22d. ADDRESS 43 GREENE ST., CUMBERLAND, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/12/66		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Rose Hill Cemetery	
24. FUNERAL DIRECTOR H. Wayne George		23d. LOCATION (City or Town) (County) (State) Cumberland, Md.		25a. REC'D. BY REGISTRAR APR 13 1966	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

04619

CERTIFICATE OF DEATH

04619

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE Maryland Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Md.	
c. LENGTH OF STAY IN b 29 days		d. STREET ADDRESS 109 Arch Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gladys		4. DATE OF DEATH Month Day Year April 4 1966	
Middle A.		Last Kime	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH 10/4/03		9. AGE (In years lost birthday) 62 yrs	
10a. LSLAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? Purrittsaville USA	
13. FATHER'S NAME Wm. B. Smith		14. MOTHER'S MAIDEN NAME Bessie R. Reel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Pt. chart		Address	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL VASCULAR HEMORRHAGE DUE TO Arteriosclerotic CARDIOVASCULAR DISEASE		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
DUE TO (b) Arteriosclerotic CARDIOVASCULAR DISEASE			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 126 N. Smokewood CUMBERLAND
20f. (City or town) (County) (State)			
21. I certify that (I) (This hospital) attended the deceased from 3-6 , 19 66 , to 4-2 , 19 66 that (I) (we) last saw the deceased alive on 4-2 19 66 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE L. Michael Reel		22b. DATE SIGNED 4-5-66	
22c. PHYSICIAN'S NAME (Type) L. Michael Reel		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-6-66	23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park
23d. LOCATION (City or Town) Cumberland, Md.		(County) (State)	
24. FUNERAL DIRECTOR James F. Scarbelli Cumberland, Md.		25a. ADDRESS 25b. REGISTRAR'S SIGNATURE APR 12 1966 Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

04620

CERTIFICATE OF DEATH

04620

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE West Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Maryland		c. LENGTH OF STAY IN lb 8 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Romney West Virginia		d. STREET ADDRESS 276 E. Main St. Romney W.Va.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print)	First Mary	Middle A.	Last Kirk
4. DATE OF DEATH 4/2/66	Month 4	Doy 2	Year 1966
5 SEX Female	6 COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 7/4/83	9. AGE (in years last birthday) 32 yrs.	10. U.S. JAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (County & State, or foreign country) Hampshire County W.Va.
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George S. Arnold	14. MOTHER'S MAIDEN NAME Virginia (Parsons) Arnold		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Susan B. Arnold, Romney, West Virginia	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>Arterio Sclerotic Heart Disease</i> DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH unk.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>PLASTIC ANEMIA IDIOPATHIC</i>			19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3-25</u> , 19 <u>66</u> , to <u>4-2</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4-2</u> 19 <u>66</u> , and that death occurred at <u>9A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <i>Michael Gluck</i>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 4/2/66
22c. PHYSICIAN'S NAME (Type) L. MICHAEL GLUCK	22d. ADDRESS 126 N. Smethwick CUMBERLAND MD		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/5/66	23c. NAME OF CEMETERY OR CREMATORIAL Fairview	23d. LOCATION (City or Town) (County) (State) Roanoke Roanoke Va.
24. FUNERAL DIRECTOR <i>Frank Kappa</i>	ADDRESS Romney, West Virginia	25a. REC'D BY REGISTRAR APR 6 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please write carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												04621	04621				
CERTIFICATE OF DEATH																	
1. PLACE OF DEATH a. COUNTY ALLEGANY			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 5 DAYS			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND			b. COUNTY ALLEGANY					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND			d. STREET ADDRESS 800 COLUMBIA AVENUE			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First MAURICE	Middle		Last KIRK		4. DATE OF DEATH APRIL 13 1966	Month	Day	Year							
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-25-1890		9. AGE (in years, months and days at last birthday) 76 yrs.	FUNDER 1 YEAR 76 months	FUNDER 24 HRS. 76 days	Hours	Min.						
10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) Ret. Millwright			10b. KIND OF BUSINESS OR INDUSTRY Celanese Fibres			11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND MARYLAND			12. CITIZEN OF WHAT COUNTRY U.S.A.								
13. FATHER'S NAME JAMES J. KIRK			14. MOTHER'S MAIDEN NAME AGNES HERSHBERGER			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) Yes			16. SOCIAL SECURITY NO. W. W. # 1 214-07-4907			17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.	Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												INTERVAL BETWEEN ONSET AND DEATH 5 days					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>Obstructive heart failure</i> (c) <i>Generalized arteriosclerosis</i>																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Advanced pulmonary hypertension & fibrosis</i>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>While at work</i>			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from June 1959 to 4-13 1966 , that (I) (we) last saw the deceased alive on 4-13 1966 , and that death occurred at 10:40 AM from the causes and on the date stated above.												22a. SIGNATURE <i>William P. Seamer</i>					
22b. DATE SIGNED 4/14/66												M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) DR. WILLIAM JAMES			22d. ADDRESS 441 N. CENTRE ST. CUMBERLAND, MD.			23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 4/16/66			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS St. Patrick's Cemetery			23d. LOCATION (City, town or county) (State) Cumberland, Md.		
24. FUNERAL DIRECTOR H. Wayne George			25a. REC'D BY REGISTRAR APR 18 1966			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>											
VR A15 (4) 20M 1/65																	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04622

CERTIFICATE OF DEATH

04622

1. PLACE OF DEATH a. COUNTY Alleghany	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN 1b 3 days	d. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland,	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
c. LENGTH OF STAY IN 1b 3 days		d. STREET ADDRESS 439 Walnut Street	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Sacred Heart Hospital	3. NAME OF DECEASED (Type or print) Bessie	First M.	Middle Klosterman	Last April	Month 24	Day 1966				
4. DATE OF DEATH 4-4-66	5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 67 yrs.	9. AGE (in years last birthday) 67 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 0	Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	10b. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (County & State, or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John Jerry Free	14. MOTHER'S MAIDEN NAME Bessie Worsing	Address								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) <input type="checkbox"/> (If yes give war or dates of service) no	16. SOCIAL SECURITY NO. None	17. INFORMANT Chart	INTERVAL BETWEEN ONSET AND DEATH 2 days							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 110X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. metastasized										
DUE TO (b) DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) M.		(County) Charles	(State) MD	
21. I certify that (I) (this hospital) attended the deceased from January 1966 to April 27 1966 that (I) (we) last saw the deceased alive on January 1966 , and that death occurred at M. from the causes and on the date stated above.										
22a. SIGNATURE Blane Schindler M.D.										
22b. DATE SIGNED 4/27/66										
22c. PHYSICIAN'S NAME (Type) Blane Schindler M.D.		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/27/66		23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park		23d. LOCATION (City, town or county) (State) Cumberland Rt 3 Maryland				
24. FUNERAL DIRECTOR Ruth E. Silcox		ADDRESS Cumberland Maryland 21502		25a. REC'D BY REGISTRAR APR 27 1966		25b. REGISTRAR'S SIGNATURE Charles Judge				
VR A15 (4) 20M 1/65		DATE		DATE		DATE				



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04623

CERTIFICATE OF DEATH

04623

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 1 DAY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		e. 15. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ENOC H.	Middle F.	Last LEASURE
4. DATE OF DEATH APRIL 14 1966	Month APRIL	Day 14	Year 1966
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 5-10-1896
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 69 yrs
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Coalminer</i>		10b. KIND OF BUSINESS OR INDUSTRY B&O R.R.	
13. FATHER'S NAME JAMES S. LEASURE		11. BIRTHPLACE (County & State, or foreign country) Cumberland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) NO		16. SOCIAL SECURITY NO. 14-10-1000	
17. INFORMANT PATIENT'S CHART		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia DUE TO 493x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO lost. (c) 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. Congestive Heart Failure WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Cerebral Vasc. Accident; Coronary Artery Disease, Failure	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) 		22b. DATE SIGNED 4/17/66	
21. I certify that (I) (this hospital) attended the deceased from 4/13 , 19 66 to 4/14 , 19 66 that (I) (we) last saw the deceased alive on 4/14 , 19 66 , and that death occurred at 456 M. from causes and on the date stated above.		22a. SIGNATURE Leo Ley	
22c. PHYSICIAN'S NAME (Type) LEO LEY,		22d. ADDRESS 456 N. CENTRE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/18/66	23c. NAME OF CEMETERY OR CREMATORIAL Sacred Heart Burial Ph.	23d. LOCATION (City or Town) Cumberland (County) Allegany (State) MD.
24. FUNERAL DIRECTOR Lewis Stein Inc. Cumb. Md.	ADDRESS	25a. RECD BY REGISTRAR APR 19 1966	25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04624 04624

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1B 3/25/64	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) (Sue) Susie Almira McFarland		4. DATE OF DEATH April 23, 1966	Month Day Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 8/27/1883		9. AGE (In years last birthday) 82 yrs.	10. FUNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (County & State, or foreign country) West Virginia
13. FATHER'S NAME George McFarland		14. MOTHER'S MAIDEN NAME Margaret Chrismore	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	17. INFRMANT P.O. Box 599, Allegany County Infirmary records. Address Cumberland, Md
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis & Hypotension (c) Paralysis due to DUE TO (d) Alzheimer's disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 49 Greene St., Cumberland, Md.
21. I certify that (I) (this hospital) attended the deceased from 3/25/64 , 19, to 4/23/66 , 19, that (I) (we) last saw the deceased alive on 4/22/66 , 19, and that death occurred at A M, from the causes and on the date stated above.		22d. DATE SIGNED 4/23/66	
22a. SIGNATURE W. B. Mathews		M.D. ATTENDING MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. ADDRESS 49 Greene St., Cumberland, Md.
22c. PHYSICIAN'S NAME (Type) Lee B. Mathews, M. D.		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 26, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Oldtown M.E. Cemetery
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		23d. LOCATION (City, town or county) Oldtown, Md.	
25a. REC'D BY REGISTRAR APR 26 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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X
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 7-16 Film 3376 5/2/66 mh

04625

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04625

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If 24 hr. delay is necessary, please execute the certificate, writing the word 'pending' in the margin in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY ALLEGANY		2 USUAL RESIDENCE (Where deceased resided, if in institution, Residence before admission) a. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN b LIFETIME				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 20 TAYLOR STREET		e. STREET ADDRESS 20 TAYLOR STREET				
3 NAME OF DECEASED (Type or print) EMMETT		First MC GUIRE	Middle MC GUIRE			
4. DATE OF DEATH APRIL 28, 1966	5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED			
8. DATE OF BIRTH AUG. 24, 1904	9. AGE (In years at birth) 61 yrs	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER	10b. KIND OF BUSINESS OR INDUSTRY SELF-EMPLOYED			
11. BIRTHPLACE (State or foreign country) FROSTBURG, MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME PETER MC GUIRE	14. MOTHER'S MAIDEN NAME MARGARET EAGAN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	16. SOCIAL SECURITY NO 218-05-6865	17. INFORMANT MRS. EMMETT MCATEER, 20 TAYLOR STREET	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 40 yr DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) CORONARY OCCLUSION CORONARY SCLEROSIS	INTERVAL BETWEEN DEATH AND MARGIN SUDDEN		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20e. PLACE OF INJURY (Home, farm factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED April 28, 1966		
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Cumberland, M.D.		
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF APR. 30, 1966	23c. NAME OF CEMETERY OR CREMATORIAL ST. MICHAEL'S CEM.	23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR <i>Marley M. Sowers</i>	ADDRESS HAFER FUNERAL HOME, 60 W. MAIN ST.	25a. REC'D BY REGISTRAR DA	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04626

CERTIFICATE OF DEATH

04626

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 1 DAY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG	
3. NAME OF DECEASED (Type or print) MARIE		First F	Middle EVELYN
4. DATE OF DEATH Month APRIL		5. LAST Month 12	6. DAY Year 1966
7. SEX FEMALE	8. COLOR OR RACE WHITE	9. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	10. DATE OF BIRTH 3-9-19
11. OCCUPATION (Give kind of work done during most of working life, even if retired) CLAIM EXAMINER		12. KIND OF BUSINESS OR INDUSTRY STATE EMPLOYMENT	
13. FATHER'S NAME ERNEST B. MCKENZIE		14. MOTHER'S MAIDEN NAME JENNIE STEVENSON	15. ADDRESS
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		17. SOCIAL SECURITY NO. 215-10-4447	18. INFORMANT PATIENT'S CHART
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coma . DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Probably hypoxia - DUE TO (c) massive carcinomas larynx & metastasis.			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
21. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
22. MEDICAL CERTIFICATION			
23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		23b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
23c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) FPC STB, MD.
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above		22. DATE SIGNED 4-12-66	
22a. SIGNATURE Vicente M. Valis		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22b. ADDRESS 113 S. CENTRE ST., CUMBERLAND, MD.
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF APR. 12, 1966	23c. NAME OF CEMETERY OR CREMATORIAL PARK FBIG. MEMORIAL PARK
24. FUNERAL DIRECTOR JOSEPH P. DURST, SR., FROSTBURG, MD.		25a. ADDRESS JOSEPH P. DURST, SR., FROSTBURG, MD.	25b. REGD. BY REGISTRAR DATE APR 18 1966
		25b. REGISTRAR'S SIGNATURE Charles Judge	



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04627 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04627

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any part is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Lonaconing, Md.

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Home of Friend

3. NAME OF
DECEASED
(Type or print)

John

James

Melvin

First

Middle

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE

W. Va.

b. COUNTY

Mineral

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Keyser,

d. STREET ADDRESS

Corwin Hotel 115 N. Main St.

Last

4.

DATE

OF

DEATH

April 16.

1966

9. AGE (in years
last birthday)

60

Months

7

Days

11

Hours

15

Min.

10. IF UNDER 1 YEAR

Months

Days

Hours

Min.

11. BIRTHPLACE (State or foreign country)

Midland, Md.

14. MOTHER'S MAIDEN NAME

Effie Morris

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or date of service)

Yes

Navy

16. SOCIAL SECURITY NO.

214-07-6377

17. INFORMANT

Elizabeth Stemple, Keyser, W. Va.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)

4201

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), setting the underlying
cause last. (b)

DUE TO

(c)

Coronary Occlusion

INTERVAL BETWEEN
ONSET AND DEATH
Sudden

Coronary Sclerosis

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

19. WAS AUTOPSY
PERFORMED?
YES NO

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m.

20d. INJURY OCCURRED
White Not White
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

BENEDICT SKITARELIC, MD.

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DATE SIGNED

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

April 17, 1966

Cumberland, Md.

(State)

22e. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

Burial 4-19-66

23. FUNERAL DIRECTOR

22c. NAME OF CEMETERY OR CREMATORIUM

St. Peters Cemetery
ADDRESS

22d. LOCATION (City, town, or country)

Westernport, Md.

(State)

Thomash Smith Jr

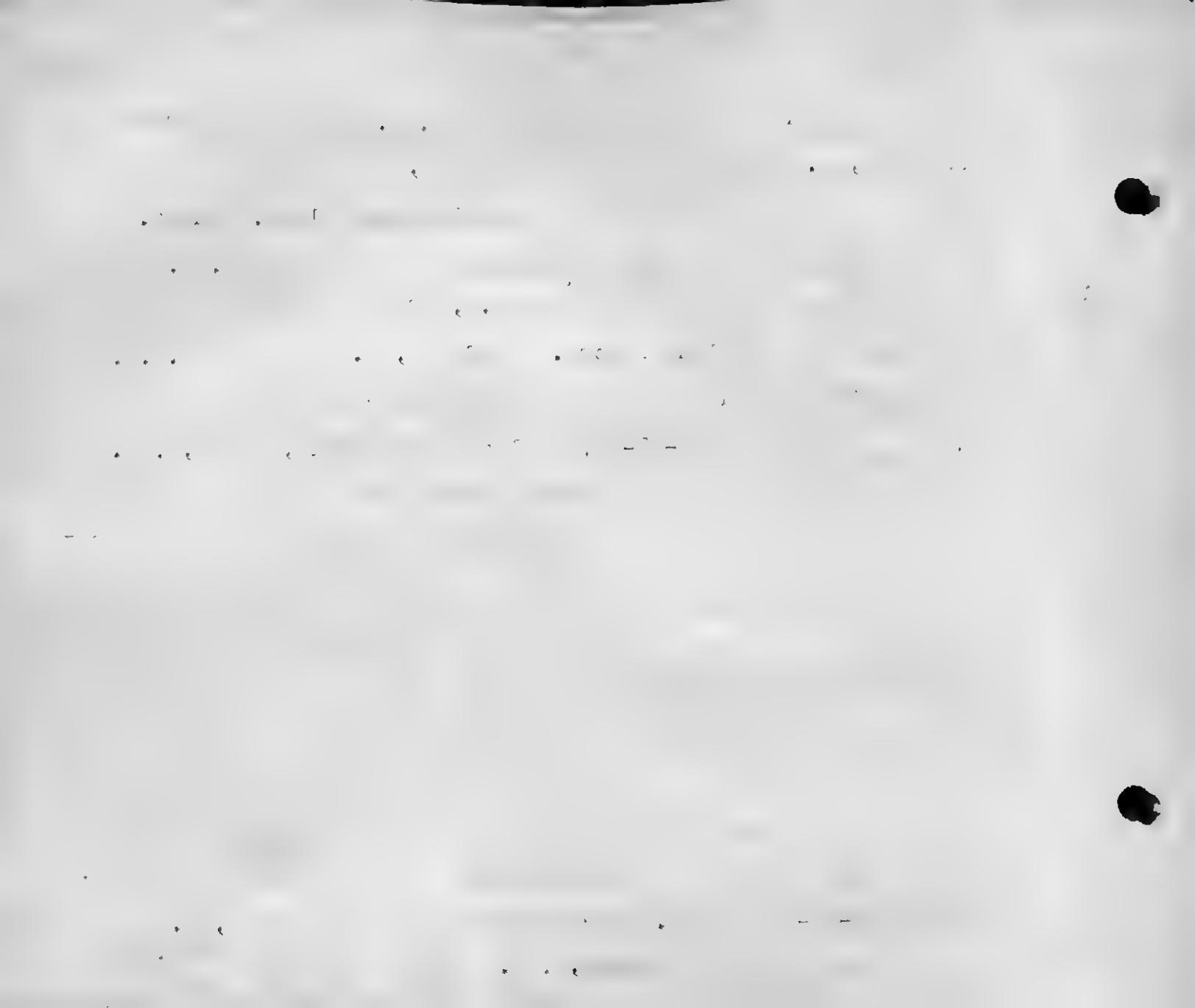
Keyser, W. Va.

4b. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE

APR 21 1966

Charles Judge

VS. AISM
SM 9/60



1
M
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04628

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04628

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maryland Cumberland			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Memorial Hospital			d. STREET ADDRESS 809 Maryland Ave.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Harvey	Middle Jacob	Last Miller	4. DATE OF DEATH Month April	Day 12
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	8. NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>	9. AGE (In years last birthday) 42	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender		10b. KIND OF BUSINESS OR INDUSTRY Cafe		11. BIRTHPLACE (State or foreign country) Fairhope, Penna.	
13. FATHER'S NAME Charles D. Miller			14. MOTHER'S MAIDEN NAME Elsie R. Deneen		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Ella Hall, Cumberland, Md. Sister	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4 / DUE TO Conditions, if any, wh ch gave rise to immediate cause (a) stating the underlying cause last			C. CORONARY OCCLUSION CORONARY SCLEROSIS AND HYPERTENSIVE CARDIOVASCULAR DISEASE		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH SUDDEN		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office building, etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>	M.D.			22. DATE SIGNED APRIL 12, 1966	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 15, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Miller Cemetery	23d. LOCATION (City or Town) (County) (State) Fairhope, Penna.	
24. FUNERAL DIRECTOR James F. Scarnelli, Cumberland, Md.		ADDRESS	25a. REC'D BY REGISTRAR APR 15 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
VR A15ME (5) 6M 1/66					



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04629

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04629

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived if institution Res dence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 403 Pennsylvania Avenue		d. STREET ADDRESS 403 Pennsylvania Av	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Myrtle	Middle A.	Last Miller
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH May 24, 1898		9. AGE (In years last birthday) 67 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John H. Norris		14. MOTHER'S MAIDEN NAME Amanda Belle Ruby	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 17. INFORMANT Walter W. Logue, Cumberland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		Coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH Sudden	
DUE TO (b) DUE TO (c)		Coronary Sclerosis -----	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> Apr. 28, 1966 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) Rt. 9, Cumberland, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 2, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Herman Cemetery	23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.	ADDRESS	25a. REC'D BY REGISTRAR MAY 3 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04630

CERTIFICATE OF DEATH

04630

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please know Carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if instit on Residence before adm ssion) a. STATE W. VA. b. COUNTY MINERAL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MARYLAND		c. LENGTH OF STAY IN lb 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGELEY Rt. # 1	
52		d. STREET ADDRESS Along St. Rt. # 28	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Leo Middle Vernon		4. DATE OF DEATH Month April Day 6 Year 1966	
5. SEX MALE COLOR OR RACE WHITE		6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	
7. DATE OF BIRTH 7-7-13		8. AGE (In years last birthday) 52 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Leroy V. Mills		14. MOTHER'S MAIDEN NAME CARRIE MAE Imes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown <input type="checkbox"/> If yes give war or dates of service) W. W. II, # 2		16. SOCIAL SECURITY NO. 217-10-4688	
17. INFORMANT Mrs. Charlotte Mills Rt. # 1 Ridgeley, W. Va		PATIENT'S CHART	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5/11 DUE TO Bleeding esophageal varices Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Hepatitis cirrhosis (c) DUE TO Chronic ethanolism		INTERVAL BETWEEN ONSET AND DEATH 7 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> p.m. 19 at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-1, 1966, to 4-6, 1966, that (I) (we) last saw the deceased alive on 4-6, 1966, and that death occurred at 2:03 PM, from causes and on the date stated above.		22. DATE SIGNED 4-7-66	
22a. SIGNATURE W. C. Spiggle		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) W. C. Spiggle, M.D.		22d. ADDRESS 126 N. Smallwood St. Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/9/66	
23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Maryland		ADDRESS	
		25a. REC'D BY REGISTRAR APR 12 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04631

CERTIFICATE OF DEATH

04631

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~remove~~ carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and ~~immediately~~, within 72 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~remove~~ carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

1. PLACE OF DEATH a. COUNTY ALLEGANY			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN b 11 DAYS		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) BARTON	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			d. STREET ADDRESS		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) THOMAS		First	Middle	4. DATE OF DEATH MOWBRAY	Month APRIL 22, 1966 Day Year
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-18-1889	9. AGE (In years last birthday) 76 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KND OF BUSINESS OR INDUSTRY Coal Mine		11. BIRTHPLACE (County & State, or foreign country) BARTON, MD.	
13. FATHER'S NAME JOHN MOWBRAY		14. MOTHER'S MAIDEN NAME MARY DARLING			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) <input type="checkbox"/> (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 216-09-2980		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Asbestosis</i> Due to <i>see father</i> <i>Pulmonary Insufficiency</i> <input type="checkbox"/> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. _____ (b) <i>Pulmonary fibrosis + pleurisy</i> <input type="checkbox"/> (c) <i>Asbestosis - Selector</i> <input type="checkbox"/>		19. INTERVAL BETWEEN ONSET AND DEATH 2 weeks <input type="checkbox"/> months <input type="checkbox"/> years <input type="checkbox"/> unk <input type="checkbox"/>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>4/11/66</i> to <i>4/21/66</i> , 1966, that (I) (we) last saw the deceased alive on <i>4/21/66</i> , and that death occurred at <i>5:12 M</i> , from <i>M</i> causes and on the date stated above.					
22a. SIGNATURE <i>Charles Weisman</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <i>4/23/66</i>		
22c. PHYSICIAN'S NAME (Type) DR. S. G. WEISMAN		22d. ADDRESS 59 GREENE ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/24/66	23c. NAME OF CEMETERY OR CREMATORIAL Laurel Hill	23d. LOCATION (City or Town) Moscow Mills, Md.	(County) (State)
24. FUNERAL DIRECTOR <i>Charles Weisman</i>		ADDRESS Westernport, Md.		25a. REC'D BY REGISTRAR APR 27 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Weisman</i>

certificate be executed within 24 hours after death.

NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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**MARYLAND STATE DEPARTMENT OF HEALTH
RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

CERTIFICATE OF DEATH

04632

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
ALLEGANY		a. STATE MARYLAND	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
McCOWE		13 MONTHS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		CUMBERLAND	
THORNE NURSING HOME		221 CARROLL STREET	
e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First ALBERT	Middle B. MULLAN
4. DATE OF DEATH		Month APRIL	Day 17 Year 1966
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
MALE		WHITE	8. DATE OF BIRTH
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS
78 yrs.		Months	Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
MACHINIST		B. & O. RR	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
ALLEGANY MARYLAND		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
WILLIAM T. MULLAN		ANNA CARLOS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFDRMANT Address	
NO		705-05-4827 PAUL A. MULLAN CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		5 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> p.m. 19		20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1964, 19, to 12 April, 1966, that (I) (we) last saw the deceased alive on 19, and that death occurred at M, from the causes and on the date stated above		22b. DATE SIGNED	
22a. SIGNATURE Clinton L. Rogers		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Clinton L. Rogers		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF APRIL 20, 1966	
23c. NAME OF CEMETERY OR CREMATORIY ST. PETER & PAUL CEMETERY		23d. LOCATION (City, town or county) (State) CUMBERLAND, MD.	
24. FUNERAL DIRECTOR BYRON KIGHT		ADDRESS CUMBERLAND, MD.	25a. REC'D BY REGISTRAR APR 22 1966
			25b. REGISTRAR'S SIGNATURE jCharles Judge

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

04633

CERTIFICATE OF DEATH

04633

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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 10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY ALLEGANY			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE W. VIRGINIA		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN lb 4 DAYS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			d. STREET ADDRESS 178 MAIN STREET		
3. NAME OF DECEASED (Type or print) First JASON Middle Clinton Last NELSON			4. DATE OF DEATH APRIL 15, 1966		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH DEC. 7, 1892	9. AGE (in years last birthday) 73 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.
11. DO USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Calendar Rn. Emp.			12. KIND OF BUSINESS OR INDUSTRY Kelly-Tire Co.		
13. FATHER'S NAME DAVID NELSON			14. MOTHER'S MAIDEN NAME MARY E. KETTERMAN		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes, W. W. # 1			16. SOCIAL SECURITY NO. 17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic C.R.			19. INTERVAL BETWEEN ONSET AND DEATH days		
1221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Arteriosclerosis					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. — 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumberland City Md			20f. (City or town) (County) (State) Cumberland, Allegany, Md		
21. I certify that (I) (this hospital) attended the deceased from 2/4/63 , 19 63 , that (I) (we) last saw the deceased alive on 4/17/66 , and that death occurred at 6:30 A.M. on 4/17/66 , from causes and on the date stated above.					
22a. SIGNATURE R. J. Williams			22b. DATE SIGNED 4/17/66		
22c. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS			22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/17/66		23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park	
23d. LOCATION (City or Town) Cumberland, Maryland					
24. FUNERAL DIRECTOR H. Wayne George			25a. ADDRESS Cumberland, Maryland		
			25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04634

CERTIFICATE OF DEATH

04634

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

FINAL After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		b. COUNTY ALLEGANY	
c. LENGTH OF STAY IN 1b 2 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART HOSPITAL		d. STREET ADDRESS YMCA	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JOSHUA	Middle T.	Last PERRIN
4. DATE OF DEATH APRIL 15 1966	Month Year	Day Year	Month Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2-17-99
9. AGE (In years last birthday) 67	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Yrs.	12. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labour		10b. KIND OF BUSINESS OR INDUSTRY DR	
11. BIRTHPLACE (County & State, or foreign country) Everett, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE		14. MOTHER'S MAIDEN NAME SUSIE WIGFIELD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 1. 2. 3. 4. 5. 6. 7. 8. 9. 0.	
17. INFORMANT PATIENT'S CHARGE		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left ventricular failure			
INTERVAL BETWEEN ONSET AND DEATH 1 week			
421 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) Arteriosclerotic CVD (c) 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Emphysema			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-12 1966 to 4-15 1966 , that (I) (we) last saw the deceased alive on 4-15 1966 , and that death occurred at 7p M, from the causes and on the date stated above.			
22a. SIGNATURE L. W. Ballin		22b. DATE SIGNED 4-16-66	
22c. PHYSICIAN'S NAME (Type) RALPH W. BALLIN, MD.		22d. ADDRESS 62 GREENE ST. CUMBERLAND, MD.	
23a. BURIAL, CREMATION, PREMDVAL (Specify) Burial		23b. DATE THEREOF 4/18/66	
23c. NAME OF CEMETERY OR CREMATORIAL Allegany Co.		23d. LOCATION (City, town or county) (State) Cumberland MD	
24. FUNERAL DIRECTOR ADDRESS Louis Stein Inc. Cumb. MD.		25a. REC'D BY REGISTRAR DATE APR 19 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE M
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04635

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04635

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. STATE ALLEGANY		CUMBERLAND MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland Md.		d. STREET ADDRESS 129 Greene Street		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hosp (D.O.A.)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Ernest M. Powell		First	Middle	Last	4. DATE OF DEATH April 21, 1966	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	W. BOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 16, 1905	9. AGE (In years past birthday) 60 yrs	FUNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) Policeman		10b. KIND OF BUSINESS OR INDUSTRY City of Cumberland		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Walter J. Powell				14. MOTHER'S MAIDEN NAME Mary Allender		Address		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Ernest M. Powell, Cumberland Md.		INTERVAL BETWEEN ONSET AND DEATH Sudden		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, injury, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) DUE TO Coronary Sclerosis								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cumberland	(County) Md.	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/25/66	23c. NAME OF CEMETERY OR CREMATORIUM St. Mary's Cem		23d. LOCATION (City or Town) Cumberland			(County) Md.
24. FUNERAL DIRECTOR Louis Stein Inc		ADDRESS Cumberland Md.		25a. REC'D BY REG STAR APR 25 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		
VR AT SME (5) 6M 1/66								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician, director, page 3 should be detached for use as the burial-transit permit. Then please stamp carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1
M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04636

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 6 DAYS		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		f. STREET ADDRESS 34 WASHINGTON ST.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		h. DAY	
3. NAME OF DECEASED (Type or print) eva MARIE		First eva	Middle *	Last PRICE	4. DATE OF DEATH APRIL 16th, 1966	Month APRIL	Day 16	Year 1966	
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 9-9-96	9. AGE (in years last birthday) 69 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UND 24 HRS. Days 0	12. IF UND 24 HRS. Hours 0	13. MIN. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME ERNEST SCHELL		14. MOTHER'S MAIDEN NAME OLIE CROSS							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
						PATIENT'S CHART			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHIAL PNEUMONIA BILATERAL 480X DUE TO FLUENZA SYNDROME									
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) FLUENZA SYNDROME									
DUE TO (c) 									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ADRENAL INSUFFICIENCY									
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) 							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Frostburg		(County) Md.	
21. I certify that (I) (this hospital) attended the deceased from 4-10 , 1966, to 4-16 , 1966, that (I) (we) last saw the deceased alive on 4-14 1966, and that death occurred at 4-16 M, from the causes and on the date stated above.		22b. DATE SIGNED 4-16-66							
22a. SIGNATURE <i>l. Michael Glick</i>		22b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
22c. PHYSICIAN'S NAME (Type) L. MICHAEL GLICK		22d. ADDRESS 126 N. SMALLWOOD CUMBERLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-19-66		23c. NAME OF CEMETERY OR CREMATORIAL F'bg. Memorial Park		23d. LOCATION (City, town or county) Frostburg		(State) Md.	
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR.,		ADDRESS FROSTBURG, MD.		25a. REC'D BY REGISTRAR APR 21 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

3
M

04637

CERTIFICATE OF DEATH

04637

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY ALLEGANY		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 15 DAYS		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 130 SEYMOUR ST.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3 NAME OF DECEASED (Type or print)	First BERTHA	Middle PROUDFOOT	Last Month Day Year APRIL 24 1966	
4 SEX FEMALE	5 COLOR OR RACE WHITE	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	7. DATE OF BIRTH OCT. 11, 1889	
8. AGE (In years last birthday) 76 yrs	9. IF UNDER 1 YEAR Months 0	10. IF UNDER 24 HRS. Days 0	11. Hours 0	12. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA
13. FATHER'S NAME HARRY COLEMAN		14. MOTHER'S MAIDEN NAME LUCETTA, DUGAN		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>arteriosclerotic cerebral vascular</i> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <i>obstruction</i> 4-72-				
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>decompensated</i>				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>fall</i>		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Cumberland, Allegany</i>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>4-24-66</i> , 19, to <i>4-27-66</i> , 19, that (I) (we) lost saw the deceased alive on <i>4-24-66</i> , 19, and that death occurred at <i>4-27-66</i> , 19, M, from causes and on the date stated above.				
22a. SIGNATURE <i>R. J. Williams</i>		22b. DATE SIGNED M.D. ATTENDING <input type="checkbox"/> PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS		22d. ADDRESS 122 S. CENTRE ST. CUMBERLAND, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/27/66	23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.
24. FUNERAL DIRECTOR <i>Charles J. Williams</i>	ADDRESS Cumberland, Maryland		25a. REC'D BY REGISTRAR APR 29 1966	25b. REGISTRAR'S SIGNATURE <i>Charles J. Williams</i>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

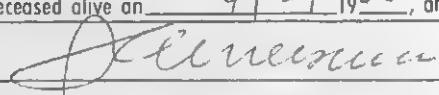
04638

CERTIFICATE OF DEATH

04638

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		b. CITY OR TOWN (If outside corporate limits, write R.R., R.R. and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 13 Days		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Peter's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Mt. Savage		d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) William E. Rice		First	Middle	Lost	4. DATE OF DEATH Month 11 25 1966	Month	Day	Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/2/96	9. AGE (In years last birthday) 70 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mining		11. BIRTHPLACE (County & State, or foreign country) Allegany Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Perry Rice		14. MOTHER'S MAIDEN NAME Sadie Resser		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W. I		16. SOCIAL SECURITY NO. 215-10-1231		17. INFORMANT Chatt	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis		DUE TO and		DUE TO Pulmonary fibrosis		INTERVAL BETWEEN ONSET AND DEATH 2 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5271				Pulmonary edema		DUE TO Unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebrovascular disease, Atherosclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) St. George's Cemetery		20f. (City or town) (County) (State) St. George's Cemetery			
21. I certify that (I) (this hospital) attended the deceased from 4/24/66 to 4/25/66 , 19 66 , that (I) (we) last saw the deceased alive on 4/24/66 , and that death occurred at 1025 M., from causes and on the date stated above.									
22a. SIGNATURE 		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-26-66					
22c. PHYSICIAN'S NAME (Type) Dr. Weisman		22d. ADDRESS 59 Greene Street							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-23-66		23c. NAME OF CEMETERY OR CREMATORIAL St. George's Cemetery		23d. LOCATION (City or Town) (County) (State) Mt. Savage, Md.			
24. FUNERAL DIRECTOR Joseph R. Durst, Sr.,		ADDRESS Frostburg, Md.		25a. REC'D BY REGISTRAR APR 29 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			



1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Margaret	Middle Jesmond	Last Robertson
4. DATE OF DEATH April 24 1966	Month April	Day 24	Year 1966
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 6-18-63
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (County & State, or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lawson A. Perdew		14. MOTHER'S MAIDEN NAME Mary Diehl	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Pt. chart		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>infective heart failure</i>		INTERVAL BETWEEN ONSET AND DEATH 2 days	
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>pneumonia</i>		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 57 Greene Street
20f. (City or town) Cumberland		(County) Rt 3	
(State) Maryland			
21. I certify that (I) (this hospital) attended the deceased from 4-24-1966 to 4-24-1966 , that (I) (we) last saw the deceased alive on 4-24-1966 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE <i>L. Brings</i>		22b. DATE SIGNED 4-25-66	
22c. PHYSICIAN'S NAME (Type) Dr. L. Brings		ATTENDING M.D. PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/27/66	23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park
24. FUNERAL DIRECTOR Ruth E. Silcox		ADDRESS Cumberland, Maryland	25a. REC'D BY REGISTRAR APR 27 1966
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



1
M
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04640

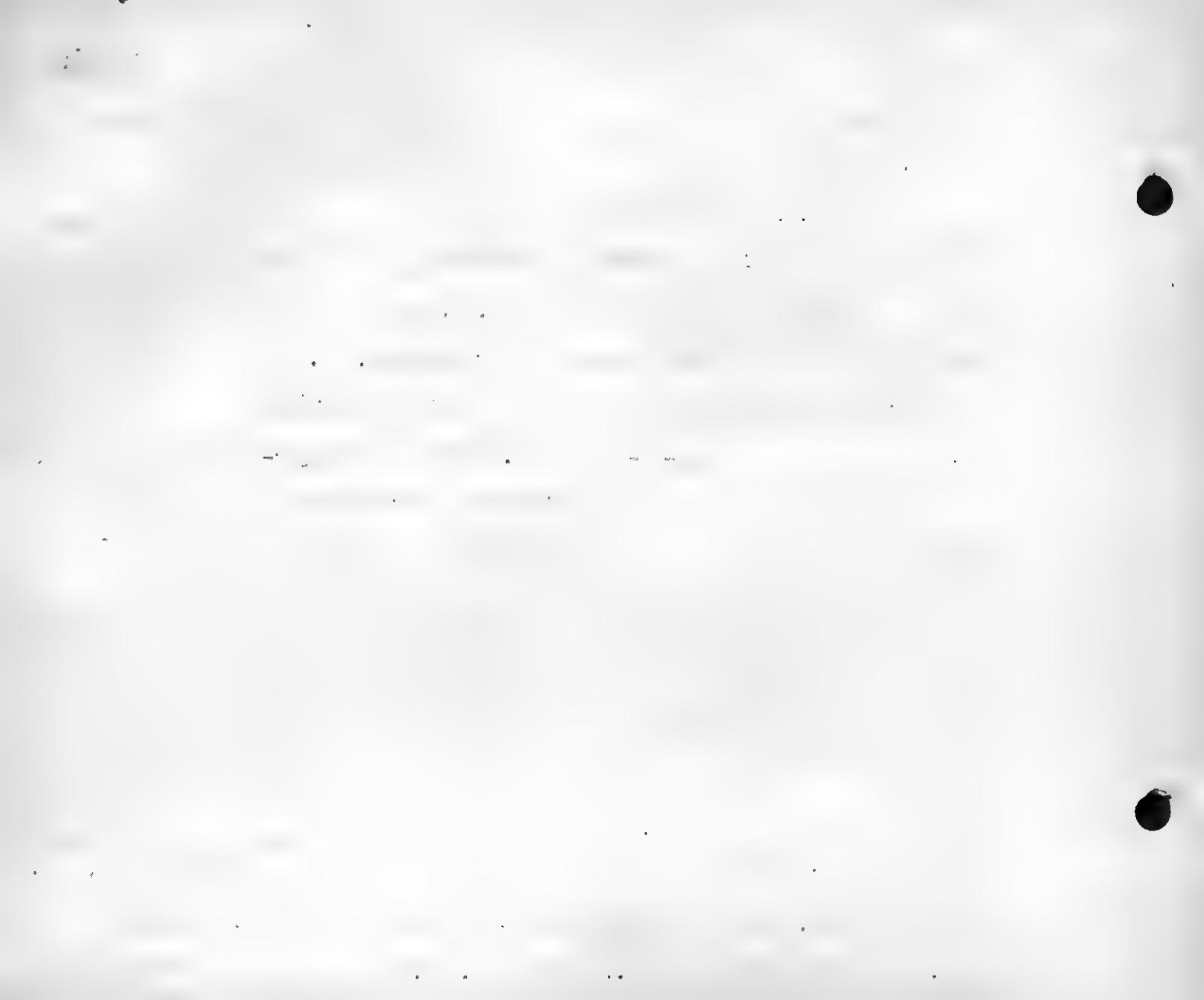
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04640

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute one certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a trial transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1b		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D O A Sacred Heart Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cresaptown		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Hayes Middle Elwood Last Robinette		4. DATE OF DEATH April 17, 1966		Month Day Year					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Oct. 7, 1888		9. AGE (In years last birthday) 77 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Self employed		11. BIRTHPLACE (State or foreign country) Flintstone, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Henry Clay Robinette		14. MOTHER'S MAIDEN NAME Minerva Jane O'Neil		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-32-2961		17. INFORMANT Mrs. Mildred Hershberger-Box 233 Cresaptown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH Sudden					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Coronary Sclerosis		---					
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20e. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Benedict Skitarelic		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 17, 1966			
EXAMINER'S NAME (Type) Benedict Skitarelic						Address (Street, city, town, or county) Cumberland, Md.			
23a. BURIAL/CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 20, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		23d. LOCATION (City, town or county) Cumberland, Maryland			
24. FUNERAL DIRECTOR John J. Hafer, 230 Baltimore Ave., Cumberland, Md.		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

2 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then ~~these~~ ^{these} should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

PLACE OF DEATH 3. COUNTY ALLEGANY		4. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE W. VA b. COUNTY MINERAL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) XRMX	First DOROTHY	Middle LORRAINE	Last ROWE
4. DATE OF DEATH 4- 29 1966	Month Year	Day	Year
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 8-9-1924
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 41 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSPECTOR		10b. KIND OF BUSINESS OR INDUSTRY TEXTILES	
13. FATHER'S NAME CARL SPRIGGS		11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MARYLAND	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. SOCIAL SECURITY NO. 218-12-5619		17. INFORMANT NETTIE E. HUSBAND HAROLD ROWE 61 CARPENTER AVE.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address Ridgeley, W. Va.	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410X		INTERVAL BETWEEN ONSET AND DEATH 3 days	
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO Harold Elbin	
		DUE TO Heart Disease	
		DUE TO 410X	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 25 1966 to Aug 25 1966 , that (I) (we) last saw the deceased alive on Aug 25 1966 and that death occurred at M. from the causes and on the date stated above.		22b. DATE SIGNED 4/29/66	
22a. SIGNATURE Dr. Blaine Schindler		22b. ADDRESS 43 Greene St. Cumberland, Md.	
22a. PHYSICIAN'S NAME (Type) Dr. Blaine Schindler		22d. ADDRESS 43 Greene St. Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/2/66	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Sunset Memorial Park		23d. LOCATION (City, town or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR H. Wayne George		25a. REC'D BY REGISTRAR MAY 3 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

01642

CERTIFICATE OF DEATH

04642

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,		c. LENGTH OF STAY IN 1b 23 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. STREET ADDRESS 534 GREENE ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Carl	Middle Herbert	Last Sell
4. DATE OF DEATH April 9 1966	Month	Day	Year
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH 11-13-02	9. AGE (In years last birthday) 63 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired metal Works self.		10b. KIND OF BUSINESS OR INDUSTRY Self.	
11. BIRTHPLACE (County & State, or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael Sell		14. MOTHER'S MAIDEN NAME MARGARET Weaver	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT PATIENT'S CHART		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) (b) Bronchogenic carcinoma with generalized metastases			
DUE TO 6 mo.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) metastases			
DUE TO 2 mo.			
(c) Generalized cachexia			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
Unknown			
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. (City or town) (County) (State)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from October 1965 to 4-9 1966 , that (I) (we) last saw the deceased alive on 4-9 1966 , and that death occurred at 2:00 AM , from causes and on the date stated above.			
22a. SIGNATURE William Wolverton		22b. DATE SIGNED 4-11-66	
22c. PHYSICIAN'S NAME (Type) WILLIAM WOLVERTON, MD.		22d. ADDRESS 108 HARRISON ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/15/66	
23c. NAME OF CEMETERY OR CREMATORIAL St. Peter & Paul Roman Catholic		23d. LOCATION (City or Town) (County) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR Louis Stein Inc. Cumb. Md.		25a. RECEIVED BY REGISTRAR APR 13 1966	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles Judge	



1 (M)
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04643

04643

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE West Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		b. COUNTY	
c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aurora	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital--DOA		d. STREET ADDRESS Box 21	
3. NAME OF DECEASED (Type or print) Harry W Shahan		First Harry	Middle W
4. DATE OF DEATH Month April		Month 8	Day Year 19 66
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 4/6/1912		9. AGE (in years last birthday) 53 yrs.	10. IF UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN		10b. KIND OF BUSINESS OR INDUSTRY RAILROAD	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY US		13. FATHER'S NAME Harry William Shahan	
14. MOTHER'S MAIDEN NAME CORA DIEHL		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service) W.W.II.	
16. SOCIAL SECURITY NO. 217-10-1997		17. INFORMANT Evelyn J. Shahan Aurora w/w	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis, Left		Address	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201		INTERVAL BETWEEN ONSET AND DEATH Sudden	
(b) Coronary Sclerosis, Left		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) factory, street, office bldg., etc.
20f. (City or town) Cumberland		(County) Maryland	
(State) Md.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED April 8, 1966		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/11/1966	23c. NAME OF CEMETERY OR CREMATORIAL AURORA
24. FUNERAL DIRECTOR Walter B Burke Rowlesburg w/w		24a. ADDRESS Walter B Burke Rowlesburg w/w	24b. LOCATION (City, town or county) AURORA
25a. REC'D BY REGISTRAR APR 15 1966		25b. REGISTRAR'S SIGNATURE Charles J. J. J.	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04644

CERTIFICATE OF DEATH

04644

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please ~~fill in~~ ^{sign} carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, with n/2 hours after death.

1. PLACE OF DEATH a. COUNTY Allwagany		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1 Day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		e. STREET ADDRESS Rt. # 6 Triple Lakes	
3. NAME OF DECEASED (Type or print) Bertha Marie Shuck		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. SEX Female	5. COLOR OR RACE White	6. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7. NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH Sept. 10, 1898		9. AGE (in years lost birthday) 67 yrs	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) W.Va. Horseshoe	
12. CITIZEN OF WHAT COUNTRY? XXXX U.S.A.		13. FATHER'S NAME William D. Lease	
14. MOTHER'S MAIDEN NAME Anne V. Lark		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.	
16. SOCIAL SECURITY NO None		17. INFORMANT Address Mr. Douglas D. Shuck Rt. # 3 Rawlings, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Cerebral Vascular Accident, presumed DUE TO a hemorrhage Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause (b) Hypertensive and Arteriosclerotic Cardiovascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 hours	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) History of old myocardial infarctions and chronic failure.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> (CAUSE OF DEATH IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from November 1964 , to April 24, 1966 , that (I) (we) last saw the deceased alive on April 24, 1966 , and that death occurred at 8:50 A.M. from causes and on the date stated above.		22b. DATE SIGNED 4-25-66	
22a. SIGNATURE <i>Charles W. Doerner, M.D.</i>		22c. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Dr. W. Doerner		22d. ADDRESS 474 N Mechanic Street	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 4/27/66	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Biertown Cemetery		23d. LOCATION (City or Town) (County) (State) Rawlings, Md.	
24. FUNERAL DIRECTOR H. Wayne George		25a. RECD BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles George	
25c. DATE APR 29 1966			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04645

CERTIFICATE OF DEATH

04645

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND.		c. LENGTH OF STAY IN lb 11 DAYS				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. STREET ADDRESS 157 NATIONAL HIGHWAY				
3. NAME OF DECEASED (Type or print) DOUGLAS		4. DATE OF DEATH APRIL 25 1966	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/>	8. NEVER MARRIED DIVORCED <input type="checkbox"/>			
9. DATE OF BIRTH 1-13-1894		10. AGE (In years last birthday) 72 yrs	11. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>			
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Mechanical Engineer.		10b. KIND OF BUSINESS OR INDUSTRY WESTERNPORT, MD.	12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME ROBERT SMITH		14. MOTHER'S MAIDEN NAME ISABELLE BLACK				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W. I		16. SOCIAL SECURITY NO. 214-07-4099	17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (c), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis with pt. Hemiplegia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>33 days</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>arteriosclerotic Cardiovascular disease</i>		DUE TO (b) <i>8 years</i>				
DUE TO (c)						
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>19</i> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <i>10 a.m.</i> , 19 <i>66</i> , to <i>25 a.m.</i> , 19 <i>66</i> that (I) (we) last saw the deceased alive on <i>24 a.m.</i> , 19 <i>66</i> and that death occurred at <i>5:20 A.M.</i> from causes and on the date stated above.						
22a. SIGNATURE <i>W. Alfred Van Ormer</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>25 a.m. 1966</i>			
22c. PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER		22d. ADDRESS 122 S. CENTRE ST.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/28/66	23c. NAME OF CEMETERY OR CREMATORIAL Rest Lawn Memorial Gardens		23d. LOCATION (City or Town) LaVale	(County) Alleg. (State) Maryland
24. FUNERAL DIRECTOR Ruth E. Silcox		ADDRESS Cumberland, Maryland 21502		25a. REC'D BY REGISTRAR APR 29 1966	25b. REGISTRAR'S SIGNATURE <i>Glenda Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1 M

04646

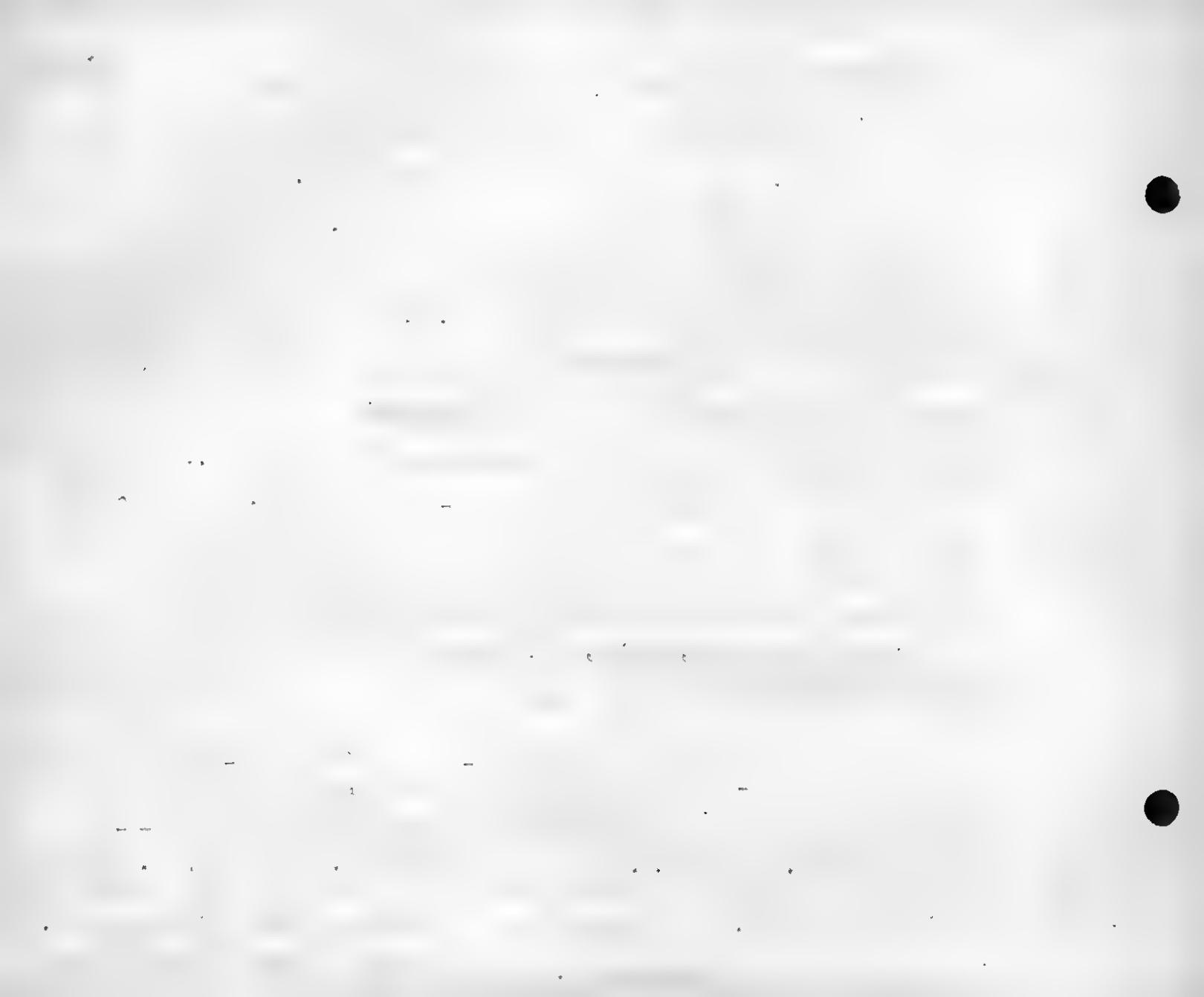
CERTIFICATE OF DEATH

04646

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1 PLACE OF DEATH a. COUNTY Allegany		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Md.		b. COUNTY Allegany	
c. LENGTH OF STAY IN lb 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		d. STREET ADDRESS 236 Paca St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First Gideon	Middle Boyd	Last Smith
4 DATE OF DEATH April 2 1966	Month	Day	Year
5 SEX Male	6 COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. NEVER MARRIED <input type="checkbox"/>
9. DATE OF BIRTH Aug. 5, 1872		10. AGE (In years at birthday) 93 yrs	11. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	11. BIRTHPLACE (County & State, or foreign country) Virginia
13. FATHER'S NAME Isaac Smith		14. MOTHER'S MAIDEN NAME Betsy Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT Address Sampson Smith, 236 Paca St., Cumberland, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Arteriosclerotic cardio-vascular disease INTERVAL BETWEEN ONSET AND DEATH 2 years			
4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO (b) DUE TO (c)	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertrophy of prostate, benign, urinary infection			
20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10 - 4 , 19 65 , to 1 - 2 , 19 66 , that (I) (we) last saw the deceased alive at 2 , 19 66 , and that death occurred at 3p M, from causes and on the date stated above.			
22a. SIGNATURE <i>Ralph W. Ballin</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) Ralph W. Ballin, M.D.		22b. DATE SIGNED 4-4-66	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 5, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Glendale Church of Bretheren
24. FUNERAL DIRECTOR John F. Hafer		23d. LOCATION (City or Town) (County) (State) Near Flintstone, Md.	25a. ADDRESS 230 Baltimore Ave., Cumberland
		25b. REC'D BY REGISTRAR APR 7 1966	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04647

CERTIFICATE OF DEATH

04647

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and again sent, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 1 MONTH		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) BEULAH			First ARMEDITH	Middle THOERIG	Last APRIL 5 1966
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 10-12-10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINE OPERATOR			10b. KIND OF BUSINESS OR INDUSTRY CELANESE CORP.		
11. BIRTHPLACE (County & State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME WILLIAM F. THEORIG			14. MOTHER'S MAIDEN NAME HARRIET A JENKINS		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO. 214-07-2616		
17. INFORMANT PT'S CHART			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage			INTERVAL BETWEEN ONSET AND DEATH 30 days		
DUE TO 443X					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Hypertensive Heart Disease			15 yrs.		
DUE TO (c) Uremic Poisoning			30 days		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cystitis acute, cholelithiasis			19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b) None		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from March 6, 1966 , to April 5, 1966 that (I) (we) last saw the deceased alive on April 5, 1966 and that death occurred at 9:35 AM from causes and on the date stated above.			22b. DATE SIGNED 4-6-66		
22a. SIGNATURE <i>James P. Hallinan M.D.</i>			M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) James P. Hallinan M. D.			22d. ADDRESS 110 BEDFORD ST. CUMBERLAND, MARYLAND.		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF APR. 9 '66		
23c. NAME OF CEMETERY OR CREMATORIAL ST. GEORGE EPISCOPAL			23d. LOCATION (City or Town) (County) (State) MT. SAVAGE, MD.		
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.			25a. REC'D. BY REGISTRAR APR 11 1966		
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT. M

04648

04648

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY			2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) CUMBERLAND		
c. LENGTH OF STAY IN lb 50 YEARS			d. STREET ADDRESS 522 LOUISIANA AVE.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 522 LOUISIANA AVE.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO XX		
3. NAME OF DECEASED (Type or print) HERMAN KARL THOMAS			First HERMAN	Middle KARL	Last THOMAS
4. DATE OF DEATH APRIL 12 1966	Month APRIL	Day 12	Year 1966		
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH JUNE 9, 1882	9. AGE (In years last birthday) 83 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST		10b. KIND OF BUSINESS OR INDUSTRY W.M. RAILROAD		11. BIRTHPLACE (State or foreign country) GERMANY	
13. FATHER'S NAME ADOLPH THOMAS			14. MOTHER'S MAIDEN NAME TERESA ?		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 705 10 796 1		17. INFORMANT ELIZABETH LAUER	Address CUMBERLAND, MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPHYXIATION DUE TO 974 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) STRANGULATION DUE TO last (c) (HANGING--SELF INFILCTED) DUE TO					
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> MD					
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.					
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF APRIL 14, 1966	23c. NAME OF CEMETERY OR CREMATORIAL SUNSET MEMORIAL PARK	23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR BYRON KIGHT	ADDRESS CUMBERLAND, MD.	25a. RECD BY REGISTRAR APR 14 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Justice</i>		



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT. M

04649

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04649

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE Maryland								
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cumberland.		c. LENGTH OF STAY IN TB hrs.								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Sacred Heart Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) Joseph		First	Middle							
4. DATE OF DEATH Timbrook		Month	Day							
5. SEX Male		6. COLOR OR RACE White	7. MARRIED WIDOWED	8. DATE OF BIRTH March 19, 1894	9. AGE (In years lost birthday) 72	F. UNDER 1 YEAR Months	10. IF UNDER 24 HRS Days	11. IF UNDER 24 HRS Hours	12. IF UNDER 24 HRS Min.	
10a. JESAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retail Supply Clerk		10b. KIND OF BUSINESS OR INDUSTRY B. & O. Rwy.		11. BIRTHPLACE (State or foreign country) Moorefield, W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME Phillip Timbrook		14. MOTHER'S MAIDEN NAME Anna Sherman		Address						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes, U. W. # 1		16. SOCIAL SECURITY NO 212-18-0819		17. INFORMANT Mr. James W. O'Brien 409 Greene St. Cumb. Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost				19. INTERVAL BETWEEN ONSET AND DEATH HOURS -----
DUE TO (b)		DUE TO (c)		CORONARY OCCLUSION		CORONARY SCLEROSIS				
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										22. DATE SIGNED April 30, 1966
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>								
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								
Address (Street, city, town, or county) Rt. # 9 Cumberland, Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/3/66		23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		23d. LOCATION (City or Town) Cumberland, Maryland		(County) (State)		
24. FUNERAL DIRECTOR H. Wayne George		ADDRESS Cumberland, Maryland		25a. REC'D BY REGISTRAR MAY 5 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.M
DR. R.J. WILLIAMS

CERTIFICATE OF DEATH

04651

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate lim.ts, write RURAL and give nearest town) CUMBERLAND		b. COUNTY ALLEGANY	
c. LENGTH OF STAY IN lb 6 HRS. 45 MIN.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 109 FEDERAL STREET	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Mary	Middle ELMA	4. DATE OF DEATH Month APRIL 28 1966
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4-4-1907
9. NEVER MARRIED DIVORCED <input type="checkbox"/>	10. K NO OF BUSINESS OR INDUSTRY Own Home	11. AGE (in years lost birthday) 59 yrs	12. IF UNDER 1 YEAR Months Days Hours Min.
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11. BIRTHPLACE (County & State, or foreign country) MARYLAND-Cumberland	
13. FATHER'S NAME CASPER GOETZ		14. MOTHER'S MAIDEN NAME ELIZABETH KREIGHLEIN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL-CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) - 60 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO (b) DUE TO (c)		<i>Arranging after her death Grief-stricken Death of wife</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Cumberland, Md.</i>		20f. (City or town) (County) (State) <i>Cumberland, Md.</i>	
21. I certify that (I) (this hospital) attended the deceased from 2/27/66 , to 4/28/66 , that (I) (we) last saw the deceased alive on 4/5/66 , and that death occurred at 4:50 PM from causes and on the date stated above.			
22a. SIGNATURE <i>R. J. Williams</i>		ATTENDING PHYS <input type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <i>4/28/66</i>	
22c. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS		22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 30, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL SS. Peter & Paul Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. ADDRESS 25b. REC'D BY REGISTRAR MAY 3 1966	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1
FOR STATE
HEALTH DEPT.M
04651

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04651

1. PLACE OF DEATH ALLEGANY		CUMBERLAND MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN TB		a. STATE MARYLAND	b. COUNTY ALLEGANY
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1814 SYLVAN AVE		d. STREET ADDRESS 814 SYLVAN AVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First LORENZA E.	Middle WATKINS	Last	4. DATE OF DEATH APRIL 14	Month 1966	Day	Year
5. SEX Male	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JULY 2, 1895	9. AGE (In years last birthday) 70 yrs.	10. UNDER 1 YEAR Months	11. UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALVAGE TIRE CO		10b. KIND OF BUSINESS OR INDUSTRY KELLY SPRINGFIELD		11. BIRTHPLACE (State or foreign country) RUCKMAN W. VA.		12. CITIZEN OF WHAT COUNTRY? USA	

13. FATHER'S NAME EDWARD WATKINS	14. MOTHER'S MAIDEN NAME ELLA DAVIS		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES W W I	16. SOCIAL SECURITY NO. REDACTED	17. INFORMANT ABEL STUMP WATKINS	Address 814 SYLVAN AVE. CUMB., MD

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shot Gun Shot Of Abdomen	
476 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO (b) _____ DUE TO (c) _____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Self inflicted				
20c. TIME OF INJURY Month, Day, Year Hour X:AM 5:00 p.m. Apr 14, 1966	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) CUMBERLAND	(County) Alleg	(State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
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ACTUAL SIGNATURE <i>Benedict Skitarelic</i>	M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/>
EXAMINER'S NAME (Type) BENEDICT SKITARELIC M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
Address (Street, city, town, or county) CUMBERLAND, MARYLAND		

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE THEREOF APRIL 16, 1966	23c. NAME OF CEMETERY OR CREMATORIAL HILLCREST BURIAL PARK	23d. LOCATION (City, town or county) CUMBERLAND, MARYLAND	(State)
24. FUNERAL DIRECTOR Louis Stein Inc. Cumb. Md.	ADDRESS	25a. REC'D BY REGISTRAR APR 19 1966	25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

1. PLACE OF DEATH 2. COUNTY		ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) B. STATE MARYLAND		104652	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b CUMBERLAND 8 HRS.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS RT 1 VALLEY RD.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First BERNARD	Middle LEO	Last WILLIAMS	4. DATE OF DEATH APRIL 19	Month 19	1 Day Year 1966
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 8-27-1895	9. AGE (in years last birthday) 70 yrs.	10. UNDER 1 YEAR Months Days Hours Min.	11. UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Mech. Helper		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN WILLIAMS		14. MOTHER'S MAIDEN NAME MARTHA NEUBAUER					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WAR I		17. INFORMANT PATIENT'S CHART		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Hemorrhage</u>							
DUE TO (b) <u>Essential Hypertension</u>							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from <u>Jun 19</u> to <u>19 Apr 1966</u> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <u>19 Apr 1966</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <i>L. Michael Glick</i>		22b. DATE SIGNED 20 Apr 66					
22c. PHYSICIAN'S NAME (Type) L. Michael Glick Md.		22d. ADDRESS 126 N. Smallwood St. Cumberland, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 22, 1966		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City, town or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. READ BY REGISTRAR APR 26 1966 DATE					
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04653

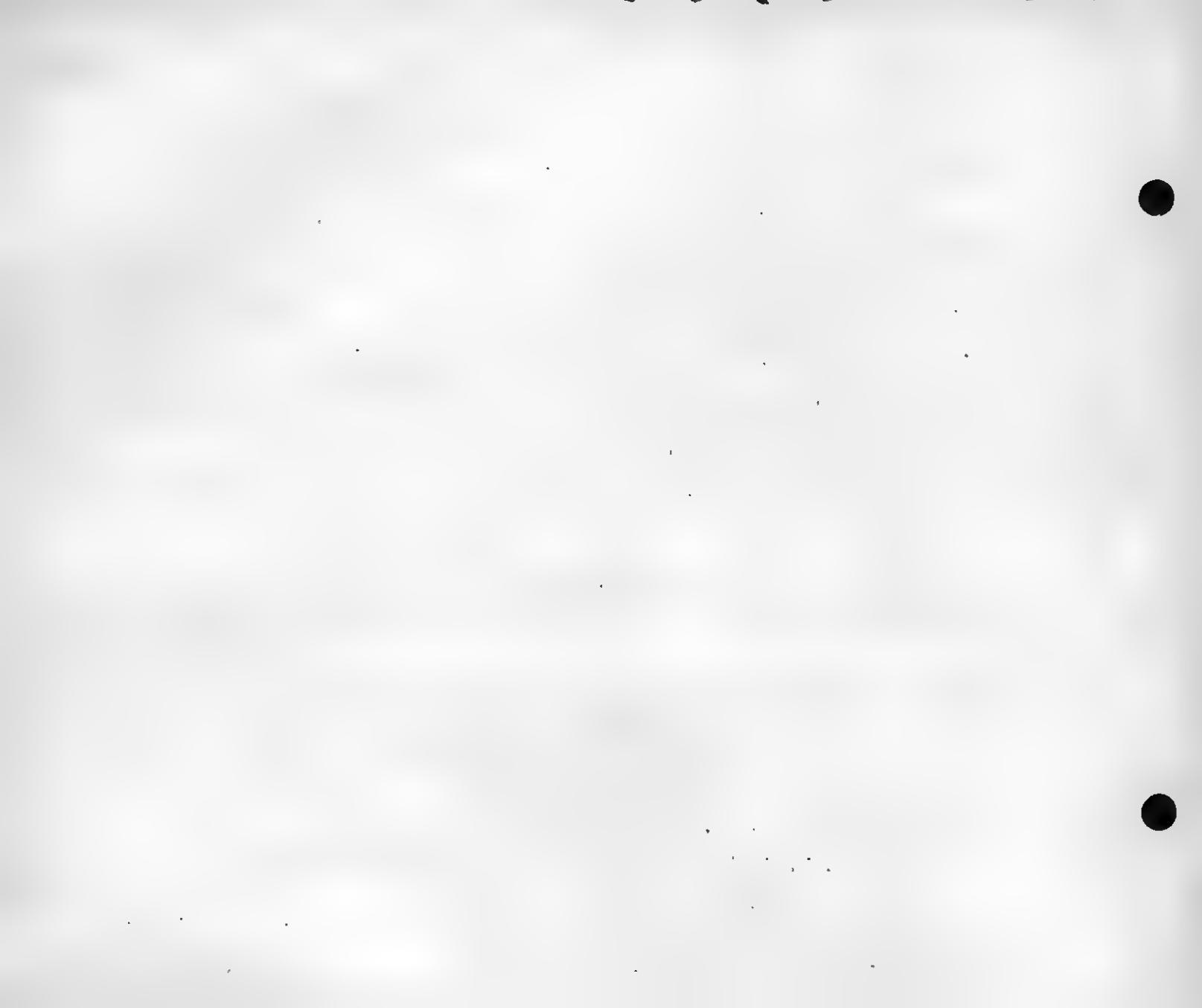
CERTIFICATE OF DEATH

04653

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		b. COUNTY ALLEGANY	
c. LENGTH OF STAY IN 1b 8 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		d. STREET ADDRESS 712 LINCOLN ST.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First WILLIAM	Middle RAY	Last WILSON
4. DATE OF DEATH	Month APRIL	Day 26	Year 1966
5. SEX	6. COLOR OR RACE MALE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 10-20-84
	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 81 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Celanese Worker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isaac Wilson		14. MOTHER'S MAIDEN NAME Jane Robertson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 214-05-7205	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO Glennys at terminal but please only when brother walked INTERVAL BETWEEN ONSET AND DEATH months years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Apr 16 1966 to Apr 26 1966 , that (I) (we) last saw the deceased alive on Apr 16 1966 , and that death occurred at M. from the causes and on the date stated above.		22b. DATE SIGNED 4/27/66	
22a. SIGNATURE DR. B. SCHINDLER		22b. ADDRESS 43 GREENE ST. CUMBERLAND, MARYLA D.	
22c. PHYSICIAN'S NAME (Type)		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/29/66	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Hillcrest Burial Park		23d. LOCATION (City, town or county) (State) Cumberland Maryland	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR APR 28 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04653

CERTIFICATE OF DEATH

Reg. Dist. No.

04654

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE Maryland		b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland.		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland.		d. STREET ADDRESS 1501 Holland St.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hosp.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Helen		First	Middle	Lost	4. DATE OF DEATH April	Month	Day	Year	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 2, 1920	9. AGE (In years last birthday) 46 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Purchasing Agent		10b. KIND OF BUSINESS OR INDUSTRY Bakery		11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Charles H. Winebrenner		14. MOTHER'S MAIDEN NAME Edna H. Feidt							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 123-18-2633		17. INFORMANT Mrs. Edna H. Winebrenner		Address 1501 Holland St. Cumb. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c):] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO Acute myocardial infarction INTERVAL BETWEEN ONSET AND DEATH 15 min.									
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Coronary Occlusion (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <u>5-13</u> , 1965, to <u>4-8</u> , 1966, that I last saw the deceased alive on <u>4-8</u> , 1966, and that death occurred at 10:30 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) William P. James M.D. 4411 1/2 Cedar Street Cumberland, Md.									
DATE SIGNED									
ACTUAL SIGNATURE William P. James									
PHYSICIAN'S NAME (Type) William P. James									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/11/66		22c. NAME OF CEMETERY OR CREMATORIAL SS. Peter & Paul Cem.		22d. LOCATION (City, town, or county) Cumberland, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Maryland		24a. REC'D BY REGISTRAR APR 13 1966		24b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04655

Item 9 Film G 376 4/20/66 inl

CERTIFICATE OF DEATH

04655

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ABRAM Middle WINFIELD		4. DATE OF DEATH APRIL 11 1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH DEC. 11, 1884
10. OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED COAL MINER		11. BIRTHPLACE (County & State or foreign country) ECKHART, MD.	
13. FATHER'S NAME GEORGE WINFIELD		14. MOTHER'S MAIDEN NAME ELIZABETH EVANS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-03-1447	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular Accident</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO (b) DUE TO (c)	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Carcinoma of Prostate</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>4-11</i> , 19 <i>66</i> to <i>4-11</i> , 19 <i>66</i> that (I) (we) last saw the deceased alive on <i>4-11</i> , 19 <i>66</i> , and that death occurred at <i>2:30</i> P.M., from causes and on the date stated above			
22a. SIGNATURE <i>WOS</i>		22b. DATE SIGNED <i>4-13-66</i>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Apr. 14, 1966</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Eckhart Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Eckhart Md.</i>	
24. FUNERAL DIRECTOR <i>John Hafer</i> ADDRESS <i>FROSTBURG MD HAFER FUNERAL HOME, 60 W. MAIN ST.</i>		25a. REC'D. BY REGISTRAR DATE <i>APR 19 1966</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



1 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

DR. R. J. WILLIAMS

CERTIFICATE OF DEATH

04656

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to a burial, cremation, or removal, and many event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limts, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN b 14 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. CITY OR TOWN (If outside corporate amits, write RURAL and give nearest town) CUMBERLAND	
d. STREET ADDRESS RT. #3, BEDFORD ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First MARY (Anna)	Middle A.	Last WINFIELD
4. DATE OF DEATH Month APRIL Day 27 Year 1966			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 1887	9. AGE (In years last birthday) 78 yrs	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (County & State, or foreign country) MARYLAND - Cumberland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOHN HIMMER		14. MOTHER'S MAIDEN NAME CATHERINE KENNIPER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	16. SOCIAL SECURITY NO.	17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Heart attack</i>			INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>
1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Heart attack</i>			
DUE TO (b) <i>Heart attack</i>			
DUE TO (c) <i>Heart attack</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>None</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> not work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <i>None</i>	20f. (City or town) <i>None</i>
21. I certify that (I) (this hospital) attended the deceased from 2/26/66 to 2/26/66 , 19, that (I) (we) last saw the deceased alive on 2/26/66 , and that death occurred at 4:45 AM M, from causes and on the date stated above.			
22a. SIGNATURE <i>R. J. Williams</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 4/29/66
22c. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS		22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Apr. 29, 1966	23c. NAME OF CEMETERY OR CREMATORIAL SS. Peter & Paul Cemetery	23d. LOCATION (City or Town) Cumberland, Md.
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS	25a. REC'D BY REGISTRAR Charles J. Judge
			25b. REGISTRAR'S SIGNATURE Charles J. Judge

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04657

04657

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
Allegany MARYLAND		Maryland Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Cumberland		60 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
York Hotel-202 Baltimore Ave.		York Hotel-202 Baltimore Ave.	
e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
George		Palmer	Wolford
4. DATE OF DEATH		Month	Day
April		24	19 66
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months Days Hours Min.
Oct. 1, 1905		60 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Clerk		Railroad	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Cumberland, Md.		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Samuel S. Wolford		Minnie G. Rush	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
no		17. INFORMANT	
		Address Brother Mr. Glen L. Wolford, Cumberland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		CORONARY OCCLUSION	
4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)	
		DUE TO (c)	
CORONARY SCLEROSIS		—	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(b)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Pulmonary Emphysema, Cor Pulmonale			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
19			20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED	
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 27, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS	23d. LOCATION (City, town or county) Cumberland, Md.
		25a. REC'D BY REGISTRAR MAY 3 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and many event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04658

CERTIFICATE OF DEATH

04658

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 8 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. STREET ADDRESS 37 BROWNING ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GRACE		First A.	Middle WOLFORD
4. DATE OF DEATH Month APRIL		Day 26	Year 1966
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9. DATE OF BIRTH MARCH 8, 1898	
10. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) MARYLAND - Cumberland	
12. CITIZEN OF WHAT U.S. STATE? U.S.A.		13. FATHER'S NAME DENTON BUCY	
14. MOTHER'S MAIDEN NAME MARY HUFF		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) NO	
16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4330 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic Cardiovascular Disease 8 days DUE TO (c) Congestive Heart Failure		INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 18, 1966 to April 26, 1966 , that (I) (we) last saw the deceased alive on April 26, 1966 and that death occurred at M. from causes and on the date stated above.		22b. DATE SIGNED 4/26/66	
22a. SIGNATURE 		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 4/26/66
22c. PHYSICIAN'S NAME (Type or print) DR. G. OVERTON HIMMELWRIGHT		22d. ADDRESS 33. VIRGINIA AVE. CENTRE ST. CUMB. MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 29, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Lybarger Cemetery
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS James F. Scarpelli, Cumberland, Md.	25a. REC'D BY REGISTRAR Madley, Penna.
			25b. REGISTRAR'S SIGNATURE Charles Judge
			MAY 3 1966

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14
FOR STATE
HEALTH DEPT.
M
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any part is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

14
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04659

04659

1. PLACE OF DEATH
a. COUNTY

ALLEGANY

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

FROSTBURG,

c. LENGTH OF STAY IN lb

LIFETIME

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

155 GREEN STREET

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

MARGARET

C.

WOODS

4. SEX

6. COLOR OR RACE

FEMALE

WHITE

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

AUG. 23rd, 1914

9. AGE (in years
last birthday)

51 yrs.

10. IF UNDER 1 YEAR

Months

Days

11. IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

MACHINE OPERATOR

10b. KIND OF BUSINESS OR INDUSTRY

PAJAMA FACTORY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY

USA

13. FATHER'S NAME

RUSSELL FORSYTHE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

213-22-3938

MRS. IDELLA W. STEVENS, FROSTBURG, MD.

Address 154 Green St.,

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)

Acute Fatty Liver

INTERVAL BETWEEN
ONSET AND DEATH
Days

880.0
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO
(b)

Ethanol Poisoning

DUE TO
(c)

Acute alcoholism

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour e.m.
p.m. 19

20d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

Home Frostburg Alleg. Md.

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

BENEDICT SKITARELIC

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DATE SIGNED

DEPUTY MEDICAL EXAMINER

April 25, 1966

Address (Street, city, town, or county) RR9, CUMBERLAND, MD.

22e. BURIAL, CREMATION
REMOVAL (Specify)

BURIAL

22b. DATE THEREOF

4-25-66

22c. NAME OF CEMETERY OR CREMATORI

F'BG. MEMORIAL PARK

22d. LOCATION (City, town, or county)

FROSTBURG,

MD.

23. FUNERAL DIRECTOR

ADDRESS

JOSEPH R. DURST, SR.,

FROSTBURG, MD.

24a. REC'D BY REGISTRAR

APR 28 1966

24b. REGISTRAR'S SIGNATURE
Charles Judge

